MINORITY RIGHTS GROUP INTERNATIONAL

FEMALE GENITAL MUTILATION: Proposals for change

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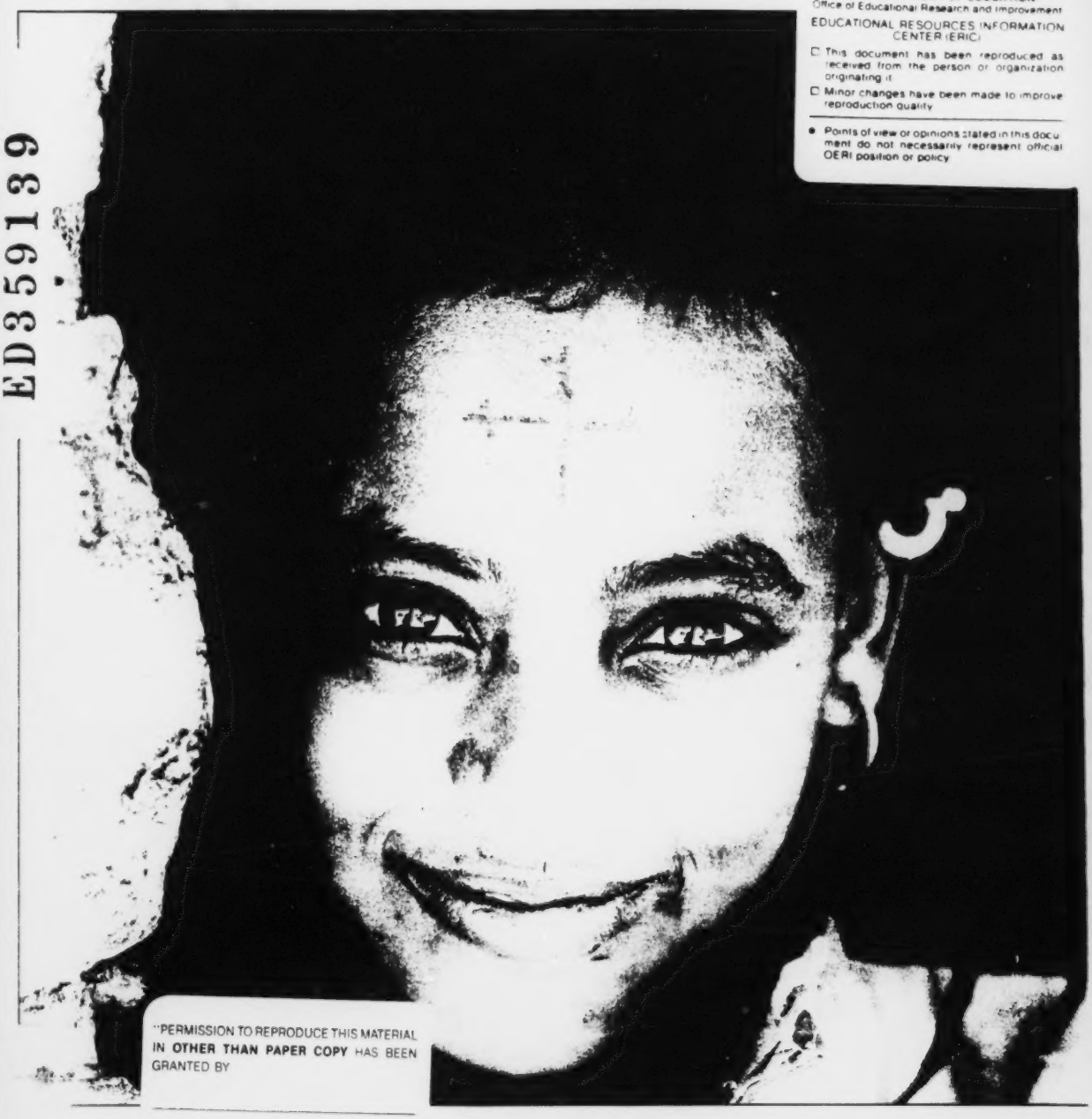

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BY EFUA DORKENOO and SCILLA ELWORTHY

MRG

THE MINORITY RIGHTS GROUP

is an international research and information unit registered in Britain as an educational charity under the Charities Act of 1960. Its principal aims are –

- To secure justice for minority or majority groups suffering discrimination, by investigating their situation and publicising the facts as widely as possible, to educate and alert public opinion throughout the world.
- To help prevent, through publicity about violations of human rights, such problems from developing into dangerous and destructive conflicts which, when polarised, are very difficult to resolve; and
- To foster, by its research findings, international understanding of the factors which create prejudiced treatment and group tensions, thus helping to promote the growth of a world conscience regarding human rights.

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Girl from Tigray, Ethiopia
NEIL COOPER

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DECLARATION ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, 1967

Article 1

Discrimination against women, denying or limiting as it does their equality of rights with men, is fundamentally unjust and constitutes an offence against human dignity.

Article 2

All appropriate measures shall be taken to abolish existing laws, customs, regulations and practices which are discriminatory against women, and to establish adequate legal protection for equal rights of men and women:

(a) The principle of equality of rights shall be embodied in the constitution or otherwise guaranteed by law;

(b) The international instruments of the United Nations and the specialized agencies relating to the elimination of discrimination against women shall be ratified or acceded to and fully implemented as soon as practicable.

Article 3

All appropriate measures shall be taken to educate public opinion and to direct national aspirations towards the eradication of prejudice and the abolition of customary and all other practices which are based on the idea of the inferiority of women.

DECLARATION ON THE PROTECTION OF ALL PERSONS FROM BEING SUBJECTED TO TORTURE AND OTHER CRUEL INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, 1975

Article 2

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.

Article 3

No state may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel inhuman or degrading treatment or punishment.

Article 4

Each State shall, in accordance with the provisions of this Declaration, take effective measures to prevent torture and other cruel, inhuman or degrading treatment or punishment from being practised within its jurisdiction.

DECLARATION ON THE RIGHT TO DEVELOPMENT, 1986

Article 2

2. All human beings have a responsibility for development, individually and collectively, taking into account the need for full respect for their human rights and fundamental freedoms as well as their duties to the community, which alone can ensure the free and complete fulfilment of the human being, and they should therefore promote and protect an appropriate political, social and economic order for development.

3. States have the right and the duty to formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals, on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting there from.

PREFACE

In Africa today, women's voices are being raised against genital mutilations still practised on babies, little girls, and women. These voices belong to a few women who, from the Arabic north to the Horn and across to western Africa, remain closely attached to their identity and heritage, but are prepared to challenge it when traditional practices endanger their lives and their health.

These courageous women are beginning the sensitive task of helping women free themselves from customs which have no advantage and many risks for their physical and psychological well-being, without at the same time destroying the supportive and beneficial threads of their cultural fabric.

Sexuality remains for many an obscure area, mined with cultural taboos, loaded with anxiety and fear. This is one of the reasons why the subject of genital mutilations provokes violent emotive reactions, both from those in the West who are shocked and indignant, and from those in Africa and the Middle East who are shocked and hurt when these facts are mentioned, and prefer to minimize the quantitative importance of the practice. Medically unnecessary, painful and extremely dangerous, these operations continue today and have affected tens of millions of women.

This report was first published by the Minority Rights Group in 1980 under the title *Female Circumcision, Excision and Infibulation: the facts and proposals for change*, containing contributions from a number of African women campaigners and edited by myself. It was published at a time when the existence of the practice was becoming known to an international audience, notably through conferences organized around the UN Decade for Women. Yet basic facts surrounding the practice were frequently presented in a distorted, sensationalist and sometimes racist way.

By presenting information in a logical, coherent and unemotional manner, the Minority Rights Group hoped both to increase awareness on the subject of female genital mutilation and to stimulate support for women and men working towards its eradication. Rather than righteous indignation, what was urgently needed was understanding of the problem and practical support to change it. Furthermore the issue needed to be placed on the programmes of the international agencies and on the human rights agenda.

The response to this report when it was first published in December 1980 was an overwhelming one. Not only did it receive sympathetic attention from the UK and international press, but hundreds of women and men sent contributions to support those who were fighting the practice. In the wake of this interest came the formation of Women's Action Campaign Against Excision and Infibulation (WAGFEI), which carried out fact-finding missions in Africa and directed funds to small-scale projects. The report was published in French, Arabic and Italian, and copies were distributed in Africa and Europe. The first TV documentary on the subject, made with the assistance of WAGFEI, appeared in the UK in 1983.

One of the first women to join WAGFEI was Stella Efua Graham (later Dorkenoo), a professional health worker from Ghana resident in the UK. In 1982, under the auspices of the Minority Rights Group, she presented detailed information on genital mutilation to the UN Commission on Human Rights. In 1983 she took the process a step further by the formation of the Foundation for Women's Health and Development (FORWARD), an independent group working to promote good health among African women, with a special emphasis on education against female genital mutilation. When this report was revised in 1983 and later in 1985, she became its co-author.

With this new edition, Efua Dorkenoo has undertaken a major revision to bring the report into the 1990s. Some of the information she presents is deeply depressing. Reports have emerged of female genital mutilations taking place in the Western world. Programmes which had once seemed so promising, in Sudan and Somalia, for example, have now collapsed as both countries have succumbed to political repression and warfare. In those countries where work continues, economic restructuring programmes have placed severe pressure on projects which work to improve the lives of women and children. Resolutions and proclamations from governments and international agencies have as yet had few positive effects on the lives of ordinary women.

However, there are some signs of positive change. In some countries, programmes in women's health, welfare and education continue, while prominent members of government and the community have spoken and acted against the practice. Urban educated Africans are beginning to reject the operation for their children while men are choosing to marry uncircumcised women. In the UK, community education schemes and sensitive and appropriate child protection measures have helped to prevent mutilation taking place. Some of these African immigrants and refugees will return to Africa and will take back a positive message and practical skills to their compatriots.

Female genital mutilation is a complex and painful issue which embraces aspects of sexuality, health, education, human rights, the rights of women and children, and the right to development. It is easy to recoil in horror – but such reactions cannot help the victims of the practice or those who are fighting to change it. This report offers a challenge to all who support the safety and well-being of women to act positively for changes in this fundamental issue.

Scilla Elworthy
MRG International Council Member,
March 1992

THE FACTS

'Any definitive and irremediable removal of a healthy organ is a mutilation. The female external genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minora or nymphae, and the clitoris covered by its prepuce, in front of the vestibule to the urinary meatus and the vaginal orifice. Their constitution in female humans is genetically programmed and is identically reproduced in all the embryos and in all races. The vulva is an integral part of the natural inheritance of humanity. When normal, there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of these exterior genital organs.'

– Gérard Zwang
Mutilations Sexuelles Féminines.
Techniques et Résultants

Types of mutilations

1. **Circumcision**, or cutting of the prepuce or hood of the clitoris, known in Muslim countries as Sunna (tradition). This, the mildest type, affects only a small proportion of the millions of women concerned. It is the only type of mutilation which can correctly be called circumcision, whereas there has been a tendency to group all kinds of mutilations under the misleading term 'female circumcision'.

2. **Excision**, meaning the cutting of the clitoris and of all or part of the labia minora.

3. **Infibulation**, the cutting of the clitoris, labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora. The two sides of the vulva are then pinned together by silk or catgut sutures, or with thorns, thus obliterating the vaginal introitus except for a very small opening, preserved by the insertion of a tiny piece of wood or a reed for the passage of urine or menstrual blood. These operations are done with special knives (in Mali, a saw-toothed knife)[1], with razor blades (in Sudan, a special razor known as *Moos el Shurfa*), or with pieces of glass. The girl's legs are then bound together from hip to ankle and she is kept immobile for up to 40 days to permit the formation of scar tissue.

4. **Intermediate**, meaning the removal of the clitoris and some parts of the labia minora or the whole of it. Sometimes slices of the labia majora are removed and stitched. It has various degrees, done according to the demands of the girl's relatives.

Operators

Most frequently, the operations are performed by an old woman of the village (known as *Gedda* in Somalia) or traditional birth attendant called *Daya* in Egypt and the Sudan). In northern Nigeria and in Egypt, village barbers also carry out the task, but usually it is done by a woman; rarely, it seems, by the mother. In Mali and Senegal, it is traditionally carried out by a woman of the blacksmith's caste gifted with knowledge of the occult.

Studies in Egypt, the Sudan and Somalia have reported excisions and infibulations being done by qualified nurses and doctors, but in small numbers. More recently, in some countries, mutilations are also being carried out in hospitals in urban areas: for example, female children one month old are excised in Bamako Hospital in Mali. Any accompanying ceremonies obviously disappear in a hospital setting, but they are disappearing equally in rural areas where traditional birth attendants do the operations.

Except in hospital, anaesthetics are never used, the child being held down either by a woman lying underneath her who pins her arms and legs with her own, or by several village women. Men are very rarely present at operations. Herb mixtures, earth or ashes are rubbed on the wound to stop bleeding.

Age

The age at which the mutilations are carried out varies from area to area, and according to whether legislation against the practice is foreseen or not. It varies from a few days old (for example, the Jewish Falashas in Ethiopia, and the nomads of the Sudan) to about seven years old (as in Egypt and many countries of central Africa) or to adolescence (among the Ibo of Nigeria, for instance, where excision takes place shortly before marriage, but only before the first child among the Aboh in midwestern Nigeria). Most experts are agreed, however, that the age of mutilation is becoming younger, and has less and less to do with initiation into adulthood.[2]

Description of an infibulation

'The little girl, entirely nude, is immobilized in the sitting position on a low stool by at least three women. One of them with her arms tightly around the little girl's chest; two others hold the child's thighs apart by force, in order to open wide the vulva. The child's arms are tied behind her back, or immobilized by two other women guests.

The traditional operator says a short prayer: "Allah is great and Mahomet is his Prophet. May Allah keep away all evils." Then she spreads on the floor some offerings to Allah: split maize or, in urban areas, eggs. Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. This nymphectomy and scraping are repeated on the other side of the vulva.

The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as the guests, "verify" her work, sometimes putting their fingers in. The amount of scraping of the large lips

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depends upon the "technical" ability of the operator. The opening left for urine and menstrual blood is minuscule.

Then the operator applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes through into the other. She sticks in three or four in this manner down the vulva. These thorns are then held in place either by means of sewing thread, or with horse-hair. Paste is again put on the wound.

But all this is not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet: strips of material rolled up into a rope immobilize her legs entirely. Exhausted, the little girl is then dressed and put on a bed. The operation lasts from 15 to 20 minutes according to the ability of the old woman and the resistance put up by the child.'

This description, by M.A.S. Mustafa, is recounted in the thesis of Dr Alan David, working in his home territory of Djibouti,[1] and is similar to the descriptions by anthropologist Annie de Villeneuve,[2] and by Jacques Lantier in *La Cité Magique*.[3] Lantier goes on to describe the wedding night in Somalia when the husband, having beaten his wife with a leather whip, uses a dagger to open her:

'According to tradition, the husband should have prolonged and repeated intercourse with her during eight days. This "work" is in order to "make" an opening by preventing the scar from closing again. During these eight days, the woman remains lying down and moves as little as possible in order to keep the wound open. The morning after the wedding night, the husband puts his bloody dagger on his shoulder and makes the rounds in order to obtain general admiration.'

Physical consequences

Health risks and complications depend upon the gravity of the mutilation, hygienic conditions, the skill and eyesight of the operator, and the struggles of the child. Whether immediate or long-term, they are grave.

Immediate complications

Short-term problems include: haemorrhage from section of the internal pudental artery or of the dorsal artery of the clitoris; and post-operative shock - death can only be prevented if blood transfusion and emergency resuscitation are possible). Bad eyesight of the operator or the resistance of the child causes cuts in other organs: the urethra, the bladder (resulting in urine retention and bladder infection), the anal sphincter, vaginal walls or Bartholin's glands. As the instruments used have rarely been sterilized, tetanus (frequently fatal) and septicaemia often result.

It is impossible to estimate the number of deaths, since the nature of the operation requires that unsuccessful attempts be concealed from strangers and health authorities, and a very small proportion of cases of immediate complication reach hospital. Nevertheless, hospital staff in all the areas concerned are very familiar with last minute and often hopeless attempts to save bleeding, terrified little girls. Operators are not held responsible by parents if death or infection results from the operation.

Long-term complications

Chronic infections of the uterus and vagina are frequent, the vagina having become, in the case of infibulation, a semi-sealed organ. Sometimes a large foreign body forms in the interior of the vagina as a result of the accumulation of mucous secretions. Keloid scar formation on the vulval wound can become so enlarged as to obstruct walking. The growth of implantation dermoid cysts as large as a grapefruit is not rare. Fistula formation (due to obstructed labour – resulting in rupture of the vagina and/or uterus) causes incontinence later in life, so that many mutilated women are continually dribbling urine.

Other grave complications include dysmennorhoea (extremely painful menstruation) since menstrual blood cannot escape freely, and young infibulated girls try to dislodge the accumulated clots with their little fingernails, if the opening is big enough. Dr Ollivier (a military doctor in Djibouti) describes a 16-year-old girl brought to the hospital with unbearable abdominal pains. She had not menstruated for several months, and had not had intercourse, but her abdomen was swollen and sensitive, with the signs of a uterus in labour. She was infibulated, with a minuscule opening. Penetration would appear to have been impossible and there was no sign of beating of a foetal heart. Dr Ollivier performed a disinfibulation (opening of the scarred vulva), and released 3.4 litres of blackish foul-smelling blood.[4]

There are other accounts of similar complications, with more tragic results: the increased size of the abdomen together with the absence of menstruation leads the family to think a girl is pregnant. She is therefore killed for the prestige of the family.[5]

The most excruciating result of excision, rendering the whole genital area permanently and unbearably sensitive to touch, is the development of neuroma at the point of section of the dorsal nerve of the clitoris. Vulval abscesses can also develop. Mutilated women, it goes without saying, feel severe pain during intercourse (known as dyspareunia), and they sometimes become sterile due to infections which ascend into the reproductive organs.

Further complications during childbirth are unavoidable for infibulated women. Splitting of the scar is always needed to let the baby out. The tough obliterated vulva has lost its elasticity and, if it is not re-opened in time, may fatally hold up the second stage of labour. The head of the baby may be pushed through the perineum, which tears more easily than the infibulation scar, so causing a high incidence of perineal tears. There is unnecessary blood loss, and the pain produced may result in uterine inertia.

The long and obstructed labour can lead to intrauterine foetal death, or brain damage to the baby. If a cut is made (bilateral or anterior episiotomy), other structures may be injured: the vagina or the cervix of the mother, or the scalp or any other part of the baby, especially if the operator is working in a hurry. Again, there is the danger of infection. Custom demands that a woman be re-infibulated, or sewn up again, after each delivery, and this may be done 12 times or more.

HIV transmission and female genital mutilation

The evidence that bleeding or open wounds increases the likelihood of infection has led to the concern that certain traditional practices affecting women and girls may lead to increased risk of infection. There is as yet no evidence that these practices are associated with a greater incidence of infection, but this has not been the subject of detailed research.

Infibulation damages the sexual organs, and the re-opening of the vulva after marriage damages them further. Both stages increase the chance of infection, which in theory can increase infection by HIV. In some cases where infibulation prevents vaginal intercourse, anal intercourse is used as an alternative; again, the resulting damage to tissue is a possible route of infection by HIV. The practice of female genital mutilation involves blood-letting and the use of one instrument in multiple operations carries a high risk of transmission of any infection, and consequently, where HIV infection is present, the risk of the transmission of HIV.

Sexual problems

In all types of mutilation, even the most 'mild' clitoridectomy (excision of the clitoris), a part of a woman's body containing nerves of vital importance to sexual enjoyment is amputated. The *glans clitoridis* with its specific sensory apparatus is a primary erogenic zone. When it has been reduced to an area of scar tissue, no orgasm can be released by its manipulation. The well-known work of William Masters and Virginia Johnson, and many others,[9] has conclusively proved that all orgasms in women originate in the clitoris, although they may be felt elsewhere. There remains confusion, however, over the terms 'clitoral orgasm' and 'vaginal orgasm'; for clarification of the issue, a more complete understanding of women's anatomy is necessary. The *Hite Report* explains the process:

> *'The vestibular bulbs and circumvaginal plexus (a network of nerves, veins and arteries) constitute the major erectile bodies in women. These underlying structures are homologous to, and about the same size as, the penis of a man. They become engorged (swollen) in the same way that a penis does.*
>
> *When fully engorged, the clitoral system as a whole is roughly 30 times as large as the external clitoral glans and shaft – what we commonly know as the "clitoris".*
>
> *Women's sex organs, though internal and not as easily visible as men's, expand during arousal to approximately the same volume as an erect penis.*
>
> *....In short, the only real difference between men's and women's erections is that men's are on the outside of their bodies, while women's are on the inside.'*

Female orgasms are triggered by the stimulation of the clitoris, whereas they are expressed by vaginal contractions:

> *'Clitoral stimulation evokes female orgasm, which takes place deeper in the body, around the vagina and other structures, just as stimulation of the tip of the male penis evokes male orgasm, which takes place inside the lower body of the male.'*[10]

The earlier a woman is mutilated, the greater is the damage, since infantile and adolescent masturbation teaches the organism and the consciousness the proper function of the sexual reaction. There is no surgical technique capable of repairing a clitoridectomy, or of restoring erogenous sensitivity of the amputated apparatus.

Very little research has been done on the sexual experiences of mutilated women. Dr A.A. Shandall found that some of the women he interviewed in the Sudan had no idea at all of the existence of orgasm. He reports on cases of tight infibulation where the husbands, unable to penetrate into the vagina, resorted to anal intercourse, or even used the urethral meatus as an opening.[11]

The consummation of a marriage may take several weeks,[12] the opening of the scar of an infibulated woman being done by the husband either with his fingers, a razor or a knife. It is questionable whether men get any satisfaction from these practices, or from intercourse with infibulated women whose tight openings are thought to be desirable. Of 300 Sudanese husbands interviewed by Dr Shandall (each of whom had more than one wife, of whom only one was infibulated), 266 stated categorically that they preferred non-excised or sunna-circumcised wives sexually. They enjoy intercourse with them more because they seem to share with them the desire, the act and the pleasure, he reports.

There is great difficulty in obtaining accurate research data on the sexual experiences of mutilated women, because the majority of them are reluctant to speak on the subject at all until the third or fourth visit to a clinic, and are generally ambivalent on questions of sex enjoyment.[13] A great deal more research is needed (and not only in countries where female genitals are mutilated) on subjects such as the relationship between male excitation and the presence of pain in the female, male concepts of female sexual pleasure, and the dichotomy between total possession (ie. a man taking extreme measures to assure himself of his wife's fidelity) and sexual enjoyment.

Westerners discussing sexual practices in cultures other than their own must be wary of moral judgements, for although Western women may not be physically mutilat-

ed, they do to this day suffer sexually inflicted pain and degradation.

Psychological consequences

Even less research has been done to date on the psychological aspects of these traditions. As a result of his work with Egyptian and Sudanese female patients, Dr T. A. Ba'asher, World Health Organization Regional Adviser for the Eastern Mediterranean on Mental Health, reports:

> *'It is quite obvious that the mere notion of surgical interference in the highly sensitive genital organs constitutes a serious threat to the child and that the painful operation is a source of major physical as well as psychological trauma.'*[14]

Many personal accounts and research findings contain repeated references to anxiety prior to the operation, terror at the moment of being seized by an aunt or village matron, unbearable pain; the subsequent sense of humiliation and of being betrayed by parents, especially the mother. On the other hand, there are references to special clothes and good food associated with the event, to the pride felt in being like everyone else, in being 'made clean', in having suffered without screaming. Clearly, if in a community sufficient pressure is put on a child to believe that her clitoris or genitals are dirty, dangerous or a source of irresistible temptation, she will feel relieved psychologically to be made like everyone else.

To be different produces anxiety and mental conflict. An unexcised, non-infibulated girl is despised and made the target of ridicule, and no one in her community will marry her. Thus what is clearly understood to be her life's work, namely marriage and childbearing, is denied her. So, in tight-knit village societies where mutilation is the rule, it will be the exception who will suffer psychologically, unless she has another very strong identity to substitute for the community identity which she has lost.[15]

There is no doubt that genital mutilation would have overwhelming psychological effects on an unmotivated girl, unsupported by her family, village, peers and community. To those from other cultures unfamiliar with the force of this particular community identity, the very concept of amputation of the genitals carries a shock value which does not exist for most women in the areas concerned. For them, not to amputate would be shocking.

These observations concern social-psychological factors rather than the central question, namely, what effects do these traumatic operations have on little girls at the moment of the operation, and as they grow up? There are references to a child dreaming of a preying mantis while under threat of operation, which disappeared once the threat of operation was removed. There are references to infibulated women being docile, incapacitated, inert.

But the fact is that in psychiatric or psycho-analytic terms, we simply do not know. We do not know what it means to a girl or woman when her central organ of sensory pleasure is cut off, when her life-giving canal is stitched up amid blood and fear and secrecy, while she is forcibly held down, and told that if she screams she will cause the death of her mother, or bring shame on her family.

THE PRACTICE

The area covered

The countries where one or more forms of female genital mutilation are practised number more than 20 in Africa, from the Atlantic to the Red Sea, the Indian Ocean and the eastern Mediterranean. Outside Africa, excision is also practised in Oman, South Yemen and in the United Arab Emirates (UAE). Circumcision is practised by the Muslim populations of Indonesia and Malaysia and Bohra Muslims in India, Pakistan and East Africa.[16]

On the map of Africa, an uninterrupted belt is formed across the centre of the continent, which then expands up the length of the Nile. This belt, with the exception of the Egyptian buckle, corresponds strikingly with the pattern of countries which have the highest child mortality rates (more than 30% for children from one to four years of age).[17] These levels reflect deficiencies of medical care, of clean drinking water, of sanitary infrastructure and of adequate nutrition in most of the countries.

The gravity of the mutilations varies from country to country. Infibulation is reported to affect nearly all the female population of Somalia, Djibouti and the Sudan (except the non-Moslem population of southern Sudan), southern Egypt, the Red Sea coast of Ethiopia, northern Kenya, northern Nigeria and some parts of Mali. The most recent estimate of women mutilated is 74 million.[18]

Ethnic groups closely situated geographically are by no means affected in the same way: for example, in Kenya, the Kikuyu practise excision and the Luo do not; in Nigeria, the Yoruba, the Ibo and the Hausa do, but not the Nupes or the Fulanis; in Senegal, the Woloff have no practice of mutilation. There are many other examples.

As the subject of female genital mutilation began to be eligible at least for discussion, reports of genital operations on non-consenting females have appeared from many unexpected parts of the world. During the 1980s, women in Sweden were shocked by accounts of mutilations performed in Swedish hospitals on daughters of immigrants. In France, women from Mali and Senegal have been reported to bring an *exciseuse* to France once a year to operate on their daughters in their apartments.[19] In July 1982 a Malian infant died of an excision performed by a professional circumciser, who then fled to Mali. In the same year, reports appeared in the British press that excision for non-medical reasons had been performed in a London private clinic.

Legislation

In Africa

Formal legislation forbidding genital mutilation, or more precisely infibulation, exists in the **Sudan**. A law first enacted in 1946 allows for a term of imprisonment up to five years and/or a fine. However, it is not an offence (under Article 284 of the Sudan Penal Code for 1974) 'merely to remove the free and projecting part of the clitoris'.

Many references have been made to legislation in **Egypt**, but after researching the available materials, all that has been traced is a resolution signed by the Minister of Health in 1959, recommending only partial clitoridectomy for those who want an operation, to be performed only by doctors.[20]

In late 1978, largely due to the efforts of the Somali Women's Democratic Organization (SWDO), **Somalia** set up a commission to abolish infibulation. In 1988 at a seminar held in Mogadishu, it was recommended that SWDO should propose a bill to the competent authorities to eradicate all forms of female genital mutilation.

In September 1982, President Arap Moi took steps to ban the practices in **Kenya**, following reports of the deaths of 14 children after excision. A traditional practitioner found to be carrying out this operation can be arrested by the Chiefs Act and brought before the law.

Official declarations against female genital mutilation were made by the late Captain Thomas Sankara and Abdou Diouf, the heads of state in **Burkina Faso** and **Senegal** respectively.

In Western countries

A law prohibiting female excision, whether consent has been given or not, came into force in **Sweden** in July 1982, carrying a two-year sentence. In **Norway**, in 1985, all hospitals were alerted to the practice. **Belgium** has incorporated a ban on the practice. Several states in the **USA** have incorporated female genital mutilation into their criminal code.

In the **UK**, specific legislation prohibiting female circumcision came into force at the end of 1985. A person found guilty of an offence is liable to up to five years' imprisonment or to a fine. Female genital mutilation has been incorporated into child protection procedures at local authority level. As yet no person has been committed in the English courts for female circumcision but since 1989 there have been at least seven local authority legal interventions which prevented parents from sexually mutilating their daughters or wards.

France does not have specific legislation on female sexual mutilation but under Article 312-3 of the French Penal Code, female genital mutilation can be considered as a criminal offence. Under this code, anybody who exercises violence or seriously assaults a child less than 15 years old can be punished with imprisonment from 10 to 20 years, if the act of violence results in a mutilation, amputation of a limb, the loss of an eye or other parts of the body or has unintentionally caused the death of the child.

In 1989, a mother who had paid a traditional woman exciser to excise her week-old daughter, in 1984, was convicted and given a three-year suspended jail sentence. In 1991, a traditional exciser was jailed for five years in France.

Intra-Africa initiatives

In 1990, at a conference on 'Traditional Practices Affecting the Health of Women and Children: How Far Forward?', held in Addis Ababa, Ethiopia, African delegates voted to support laws to forbid the practice of female genital mutilation, with punishment for all those who undertake these practices.

The first United Nations Human Rights seminar on 'Traditional Practices' was held in Ouagadougou, Burkina Faso, in May 1991. It recommended legislation, education and other measures for the abolition of harmful traditional practices. Whether legislation is effective or not, and whether it is to be recommended or simply drives the practice underground, inflicting worse pain and risk,[3] are among the questions discussed by experts from some of the countries concerned, in the second part of the report.

History

Female sexuality has been repressed in a variety of ways in all parts of the world throughout history and up to the present time. Female slaves in ancient Rome had one or more rings put through their labia majora to prevent their becoming pregnant. Chastity belts were brought to Europe by the Crusaders during the 12th Century. Until very recently, clitoridectomy was performed as a surgical remedy against masturbation in Europe and in the USA, and unnecessary genital surgery continues in the west today.

However, the customs and beliefs surrounding the various forms of female genital mutilation are so widespread and so tenacious, that far more research needs to be done on their origins and past and present practices. It is not possible as yet to conclude whether the practice originated in one area or evolved independently in several.

Marie Assaad feels that there is sufficient evidence to assume that infibulation was practised in ancient Egypt, and that it was perhaps there that the custom originated.[4] An alternative explanation is that it could have been an old African puberty rite that came to Egypt by diffusion. Infibulation is known in the Sudan as 'Pharaonic circumcision' and in Egypt it is referred to as 'Sudanese circumcision'. Certainly, the practice was widespread in the pre-Islamic era, in Egypt, Arabia and the Red Sea coasts.[5] We need to know why the custom has taken hold and survived in some communities, and not in others, and whether it is likely to continue and in what form.

Contemporary practices

Opinions are very divided as to whether the practice is disappearing because of legislation or social and economic changes. Esther Ogunmodede, for instance, believes that in Nigeria, Africa's most populous country, the tradition is disappearing but extremely slowly, with millions of excisions still taking place. She reports that in areas where the operations are done on girls of marriageable age, they are 'running away from home to avoid the razor'. This confirms Fran Hosken's assertion that operations are being done at earlier and earlier ages, in order that the children should be 'too young to resist'. Fran Hosken does not think that the custom is dying out, and she indisputably has the best published range of information concerning all the countries where the practice is known. Although it appears the practice continues in remote areas, because the consciousness of Eritrean women has changed dramatically during the war years, it is easier to persuade men and women to let go of this practice.

An interesting development took place in Ethiopia during the years of civil warfare which only ended in 1991. When the Eritrean People's Liberation Front (EPLF) occupied large areas from January 1977 to December 1978, among many other reforms, they categorically and successfully forbade genital mutilation and forced marriage. In fact, the reason given for the large numbers of young women in the EPLF army was that they were running away from home in other parts of Ethiopia to avoid forced marriage and the knife.[6]

Since 1983, the number of educational programmes initiated to raise public awareness of the health risks associated with female genital mutilation at local, national and international level have increased. The media have played a major role in bringing this issue from the domestic to the public domain. As a result of these efforts it can be said that the taboo surrounding even the public mention of the practice has at last been broken. There is an increase in public awareness of the harmful effects of female genital mutilation.

It has been noted that female genital mutilation is becoming unpopular amongst the urban elite in some African countries. In Sierra Leone, for example, Koso-Thomas claims that urban men are willing to marry uncircumcised women, in particular when the marriage is not prearranged.[7]

In general, among urban educated women, reasons often cited against female genital mutilation include the pointlessness of mutilation, health risks and reduction of sexual sensitivity. The last reason points to a changing attitude towards women's fundamental human rights amongst urban Africans.

In the main, the practice continues to be widespread among large sectors and groups within Africa. Those in favour of the practice are noted in the 1986 UN study[8] to be a passive majority who refer back to traditional society, without necessarily sharing that society's values.

In some cases, the practice appears to be spreading to population groups who traditionally never practised female genital mutilation, eg. as observed with city women in Wau, Sudan, who regard it as fashionable, and among converted Moslem women in southern Sudan who marry northern Sudanese men.[9]

Furthermore, even in areas where some groups are turning against the practice, the absolute numbers affected may be increasing. Rapid population growth in Africa means greater numbers of female children are born, who in turn are exposed to the risk of mutilation.

Motives for and functions of female genital mutilation

What are the forces which motivate a mother to subject her daughters to such drastic operations, undertaking such risks?

At first glance the different reasons given are bewildering, often conflicting, and always at odds with biological fact. They are worth examining in some detail, firstly simply *because* they are believed in, and with such tenacity. But the question then remains as to *why* they are believed in.

Generally, the reasons given, as they appear in research papers, interviews and testimonials, fall into four main groups: psycho-sexual, religious, sociological and hygienic.

1 Psycho-sexual. There is frequent mention (Mali, Kenya, Sudan, Nigeria) of the clitoris being believed to be an aggressive organ, threatening the male organ and even endangering the baby during delivery. In some areas, notably Ethiopia, people believe that if the female genitals are not excised, they will dangle between the legs like a man's.

More deeply rooted in mythology is the belief that both the female and the male sex exist within each person at birth. The clitoris representing the masculine element in a young girl, and the foreskin representing femininity in a boy, must both be excised to demarcate clearly the sex of the person.[28]

Very frequently, the reason offered by both women and men is 'the attenuation of sexual desire'. Since the focus of this desire is clearly recognized to be the clitoris, excision is believed to protect a woman against her oversexed nature, saving her from temptation, suspicion and disgrace, whilst preserving her chastity.

These beliefs must be understood in context of societies where female virginity is an absolute prerequisite for marriage, and where an extramarital relationship provokes the most severe penalties. So strong is the association of mutilation with premarital chastity that in many areas a non-excised girl (in Somalia, a non-infibulated girl) is ridiculed and often forced to leave her community, and regardless of her virginity will stand little or no chance of marriage.

In societies where a man has several wives, it is said that since it is physically impossible for him to satisfy them all, it helps if they are not too demanding.

Although the intention of the operation may be to diminish a woman's desire, the facts, from a medical point of view, are that excision of the clitoris reduces sensitivity, but it cannot reduce desire, which is a psychological attribute. Offering as a reason for infibulation 'the preservation of virginity and the prevention of immorality' is odd on a strictly practical level, since refibulation is easily done to look like the original one, whereas a ruptured hymen is more difficult to repair. Thus infibulation can be construed as giving a girl more chances to 'misbehave'.[29] Cases are reported from Somalia, where most husbands are polygamous and where divorce is cheap, of women paid for, married, divorced, re-infibulated, paid for and married again five times or more.

In the course of his research in the Sudan, Dr A.A. Shandall examined 200 prostitutes, of whom 170 had been infibulated, a rate actually higher than that among hospital patients. He concludes:

> ***'Infibulation does not confer any protection or deterrent action on females. Moreover, the vulval skin diaphragm, being an artificially constructed device, can always be reconstructed without any suspicion that this is not the original... in the writer's opinion, infibulation would encourage immorality rather than protect against it.'***[30]

The Tagouana of the Ivory Coast believe that a non-excised woman cannot conceive,[31] whereas the Yoruba used excision as a form of contraception: since they believed that sperm found its way into a nursing mother's milk with adverse effects for the child, she went without sex for 18 months of breastfeeding, and the fact of having been circumcised made it easier to bear a sexless life.[32]

2 Religious. Excision and infibulation are practised by Moslems, Catholics, Protestants, Copts, Animists and non-believers in the various countries concerned. The custom has, however, frequently been carried out in the genuine but erroneous belief that it was demanded by the Islamic faith, or perpetrated as a required Islamic custom. Dr. Taha Ba'asher, for the World Health Organization (WHO) for the Eastern Mediterranean, clarifies the position:

> ***'Among Moslem communities in Egypt and the Sudan, for example, it is not uncommon to find that female circumcision [clitoridectomy and infibulation] has been traditionally practised under the pretext of adherence to religious principles. It is remarkable that this custom is no longer observed in leading Arab countries such as Saudi Arabia, the cradle of Islam and the centre of the Holy Lands. With such a wide diversity between Moslem communities, it is not surprising to come across conflicting views regarding the place of female circumcision in religious interpretation.***
>
> ***'Nonetheless, it is important to emphasize here that in the absence of any clear reference in the Holy Koran and in confirmed traditions of the Prophet Mohamed, leading Islamic theologians, such as Sheikh Shaltout refuted the argument based on religious doctrine for the practice of female circumcision. Some of the confusion which may have arisen with regard to religious interpretation is probably due to generalization from male circumcision to the female. While there is a general consensus of opinion that circumcision was one of the commands, when the Lord made trial of the Prophet Abraham, there is no clear indication in the case of female circumcision. Even the often quoted saying of prophet Mohamed to the traditional practitioner, Om Atteya, advising her to reduce but not to destroy, was challenged as unreliable and unauthenticated. The Mufti of the Sudan, Sheikh Ahmed El Taher, in reviewing the subject in 1946, clearly stated that the words 'embellishment', 'preferable' and 'commendable' do not imply obligation.'***[33]

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In the opinion of Dr Hassan M. Hathout of the faculty of Medicine of Kuwait University, whose views are supported by Dr Ali Abdul Monem, Professor of Sharia at Kuwait University:

> *'It is incorrect to assert that female circumcision is 'Sunna' (Tradition) in Islam. Only male circumcision is sunna in Islam, a tradition taken from the Prophet Abraham which remained and is still performed in Judaism.'*

There is clearly no basis whatsoever in any religious precept for the practice of infibulation. In many countries the Moslem population continues to believe that the non-excised woman is impure in a religious sense; the words used bear witness. For example, among the Bambara in Mali, the word for excision is *Seli ji* (ablution).

3 Sociological. Some scholars explain the practice in terms of initiation rites, of development into adulthood. In many areas (Northern Sudan, Kikuyu in Kenya, Tagouana in the Ivory Coast, Bambara in Mali), an elaborate ceremony surrounded, and in some cases still surrounds, the event – with special songs, dances and chants intended to teach the young girl her duties and desirable characteristics as a wife and mother; with ritual rich in symbolism; with special convalescent huts for the girls attended only by the instructress and cut off from the rest of society until their emergence, healed, as marriageable women; or simply with special clothes and food.

However, it seems that today in many of these societies the ceremonial has fallen away; both excision and infibulation are performed at a much younger age that cannot be construed as having anything to do with entry into adulthood or marriage, and the child's role in society does not change at all after the mutilation.

Assitan Diallo devoted her thesis, entitled *L' Excision en Milieu Bambara*, to discovering whether in Mali today excision possesses the same functional value as in traditional society, whether it still has its initiation significance. She goes deeply into the details of ritual ceremonies, and finds from her respondents – who are women, excised some time ago, and men, considering the excision of their children today – that these ceremonies have in most cases disappeared. The traditional songs are no longer taught to the girls, and not one of her respondents had received instruction concerned with initiation into adulthood. Thirty-two per cent of her respondents, male and female, said that hygiene was the main justification for excision, whereas 23% said it was custom, and 23% had no explanation at all. She concludes from her research that 98% of excisions are carried out before puberty, and 53% before one year old.

In the absence of symbolism, with no feeling of 'stepping into a new life', and stripped of the rejoicing of the community, the psychological damage caused by the mutilation is likely to be more grave, and the physical pain harder to bear.

On a strictly practical level, a bride price cannot be obtained if a girl is not 'pure'. In Nigeria, the operation serves the purpose of enabling the potential mother-in-law to discover whether or not the girl is a virgin:

> ***If she is found not to be a virgin, the husband-to-be has the right to reject her and refuse to go along with the marriage. A row ensues and a refund of the dowry has to be made. The disgraced family is stigmatized, and the girl may have to leave home to find a husband outside of her community.***[34]

4 Hygiene and aesthetics. In countries toward the eastern areas of practice in Africa (Egypt, Sudan, Somalia, Ethiopia), the external female genitals are considered dirty. In Egypt, for instance, the uncircumcised girl is called *Nigsa* (unclean) and bodily hairs are removed in efforts to attain a smooth, and therefore clean, body. The same sentiment appears in Somalia and the Sudan where the aim of infibulation is to produce a smooth skin surface, and women questioned insist that it makes them cleaner.

Yet in practice infibulation clearly has the effect opposite to that of promoting hygiene; urine and menstrual blood, which cannot escape naturally, secrete and result in discomfort, odour and infection.

Individuals interviewed in Katiola in Mali maintained that the clitoris is ugly.[7] Similarly it is sometimes considered that female genitals are ugly or disfiguring in their natural state. However, the idea of female and male genitals being dirty or ugly is not confined to those who practise female genital mutilation. They are ideas which are deeply rooted and widely accepted in many areas of the world. It is the responses and practices which are different.

Yet none of these reasons, together or separately, adequately explains why the central core of the custom has persisted, when many of the given reasons for it have either disappeared or are clearly given little or no credibility and a significant proportion of respondents in every survey cannot think of any reason at all why they do it, apart from the fact that it is done. There are a number of possible explanations, but there is probably no single explanation:

- Women have been persuaded, over centuries, to see their sexual impulses in terms of what suits men. This suggestion must be considered in context of the total economic and social structure of the societies concerned, where marriage is the only secure future for a woman.
- It is an irreplaceable source of revenue for operators – mostly older women – who can bring to bear the influence of other older female relatives of the child to have it done.
- Perhaps the reason why it is women themselves who perpetrate the practice with such zeal lies in their own suffering:

  'If I submitted to this and bore it, then so shall those who follow.'

  (Indeed Dr Shandall, in his interviews of older Sudanese women, found that 35 out of 100 admitted that they had insisted on infibulation for their children and grandchildren out of spite.)
- Since mutilations are less visible than, for instance, would be the amputation of children's noses, health

education campaigns have not been directed towards them. In Esther Ogunmodede's words, describing the situation in Nigeria:

'Since there are no data or records of the distress and dangers caused by the operations, it is difficult to convince people as to the urgency of dealing with it.'[36]

- Western efforts to eliminate the practice, on the part of missionaries or colonial administrators, have simply served to confirm in people's minds that colonial destruction of traditional customs weakens their societies and exposes them to the ill-effects of Western influence.
- No forceful replacement, in terms of community identity, has been put forward to convince people to dispense with the custom (except in rare cases like Eritrea). On the contrary, Jomo Kenyatta, the leader of the anti-colonial movement and the first president of Kenya, made resistance to the elimination of excision one of the cornerstones of his national liberation campaign.[37] This continues to make the subject particularly difficult to discuss or research in Kenya.

Attitudes of health professionals

Medical experts can find no advantage whatsoever in circumcision, excision or infibulation for ordinary healthy women. The harmful consequences have been enumerated by doctors, gynaecologists, obstetricians and paediatricians in Egypt, Somalia, Sudan, Kenya, Djibouti, Mali, Nigeria, Burkina, Ghana and the Ivory Coast.

Dr Gisim Badri, of Ahfad University College for Women, reported on the views of 43 Sudanese gynaecologists.[38] All agreed that any form of mutilation was bound to create medical complications. Every respondent believed that it was a harmful and unnecessary practice and that an effort should be made to put an end to it. They were unanimous that a wide campaign of publicity was needed, showing not only the dangers of mutilations, but also the erroneous belief that it was required by religion. However, Dr Badri reports:

'This belief is not shared by another important group of health personnel, namely the midwives. In a questionnaire answered by 40 midwives in Khartoum and Port Sudan, 10% of them expressed the view that female circumcision of the 'sunna' type should be continued... Since the midwives are the persons who actually perform the operations, a great effort should be made to educate them and point out to them the errors of their assumptions.'

A study of the views of nurses was carried out in the late 1970s in Alexandria, Egypt, by Eleanor Smith, for Project Hope. It found that 63% of 135 nurses interviewed did not know about the possible form of the operations, while 32% refused to answer the question about who usually performs the operations. An overwhelming 83% believed there were no disadvantages, and 29% said they would excise their own daughters, mostly for aesthetic reasons.

Within the countries most affected, there appears therefore to be a wide spectrum of opinion and belief even among trained medical personnel. This only serves to emphasize the problems of educating professionals in the full implications of the practice, not only doctors but nurses and paramedics.

There is great danger in treating the issue purely as a health one. And that is the tendency to 'clean up' the gory aspects of the operations by either offering to perform them in hospitals, or by providing midwives and other operators with anaesthetics and penicillin. Indeed, thousands of health kits issued by international health organizations have been used for just this purpose – 'sanitizing' the custom,and thus effectively removing some of the health-based objections. The temptation to reduce pain and death by offering to do the operations in hospitals 'in the meantime' must be refused.

In 1982 WHO issued a statement that female circumcision should never be carried out by professional medical staff in any setting. Despite this statement and many resolutions made by professional bodies against female mutilation, it was reported in a UN Human Rights Seminar on Traditional Practices, held in Burkina Faso in May 1991, that medical personnel, for reasons of financial gain, are replacing midwives and traditional circumcisers and are conducting circumcisions in hospitals.

THE ISSUES

Female genital mutilation is a complex issue, for it involves deep-seated cultural practices which affect millions of people. However, it can be divided into (at least) four distinct issues.

1 Rights of women. Female genital mutilation is an extreme example of the general subjugation of women, sufficiently extreme and horrifying to make women and men question the basis of what is done to women, what women have accepted and why, in the name of society and tradition.

The burning of Indian widows and the binding of the feet of Chinese girl children are other striking examples, sharp enough and strange enough to throw a spotlight on other less obvious ways in which women the world over submit to oppression. It is important to remember that all these practices are, or were, preserved under centuries upon centuries of tradition, and that foot-binding was only definitively stopped by a massive social and political revolution (replacing the many traditions which it swept away by offering an entirely new social system, revolutionary in many aspects: landownership, class system, education, sex equality, etc.) which had been preceded by years of patient work by reformers.

Thus, to be successful, campaigns on female genital mutilation should consider carefully not only eliminating but replacing the custom. (The example of Eritrea, previously quoted, is illuminating here.) Furthermore, such success may be predicated on long-term changes in attitudes and ideologies by both men and women.

A major international expression of the goal of equal rights for women was taken in December 1979, when the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women. This came into force in September 1981. The comprehensive convention calls for equal rights for women, regardless of their marital status, in all fields – political, economic, social, cultural and civil. Article 5(a) obliges state parties to take:

> *'All appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.'*

To succeed in abolishing such practices will demand fundamental attitudinal shifts in the way that society perceives the human rights of women. The starting point for change should be educational programmes that assist women to recognize their fundamental human rights. This is where UNESCO, the UN Centre for Human Rights and international agencies could help by supporting awareness-building programmes.

2 Rights of children. An adult is quite free to submit her or himself to a ritual or tradition, but a child, having no formed judgement, does not consent but simply undergoes the operation (which in this case is irrevocable) while she is totally vulnerable. The descriptions available of the reactions of children – panic and shock from extreme pain, biting through the tongue, convulsions, necessity for six adults to hold down an eight-year-old, and death – indicate a practice comparable to torture.

Many countries signatory to Article 5 of the Universal Declaration of Human Rights (which provides that no one shall be subjected to torture, or to cruel, inhuman or degrading treatment) violate that clause. Those violations are discussed and sometimes condemned by various UN commissions. Female genital mutilation, however, is a question of torture inflicted not on adults but on girl children, and the reasons given are not concerned with either political conviction or military necessity but are solely in the name of tradition.

The Declaration of the Rights of Children, adopted in 1959 by the General Assembly, asserts that children should have the possibility to develop physically in a healthy and normal way in conditions of liberty and dignity. They should have adequate medical attention, and be protected from all forms of cruelty.

It is the opinion of Renee Bridel, of the *Fédération Internationale des Femmes de Carrières Juridiques*, that:

> *'One cannot but consider Member States which tolerate these practices as infringing their obligations as assumed under the terms of the Charter [of the UN].'*[9]

In September 1990, the United Nations Convention on the Rights of the Child went into force. It became part of International Human Rights Law. Under Article 24(3) it states that:

> *'States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.'*

This crucial Article should not merely remain a paper provision, to be given lip service by those entrusted to implement it. Members of the UN should work at translating its provisions into specific implementation programmes at grassroots level. Much could be learnt (by African states in particular) from countries with established child protection systems.

3 The right to good health. There is no medical reputable practitioner who insists that mutilation is good for the physical or mental health of girls and women, and a growing number offer research indicating its grave permanent damage to health, and underlining the risks of death. Medical facts, carefully explained, may be the way to discourage the practice, since these facts are almost always the contrary of what is believed, and can be shown and demonstrated.

Those UN agencies and government departments specifically entrusted with the health needs of women and chil-

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dren must realize that it is their responsibility to support positive and specific preventative programmes against female genital mutilation, for while the practice continues the quality of life and health will inevitably suffer. However, this approach, if presented out of context, ignores the force of societal pressures which drive women to perform these operations, regardless of risk, in order to guarantee marriage for their daughters, and to conform to severe codes of female behaviour laid down by male-dominated societies.

4 The right to development. The practice of female genital mutilation must be seen in the context of underdevelopment,[40] and the realities of life for the most vulnerable and exploited sectors – women and children. International political and economic forces have frequently prevented development programmes from meeting the basic needs of rural populations. With no access to education or resources, and with no effective power base, the rural and urban poor cling to traditions as a survival mechanism in time of socio-economic change.

In societies where marriage for a woman is her only means of survival, and where some form of excision is a prerequisite for marriage, persuading her to relinquish the practice for herself or for her children is an extraordinarily difficult task. Female (and some male) African analysts of development strategies are today constantly urging that the overall deteriorating conditions in which poor women live be made a major focus for change, for unless development affects their lives for the better, traditional practices are unlikely to change.

●

INTERNATIONAL INITIATIVES AND ACTION

Female genital mutilation is an international issue. It exists in dozens of countries. It increasingly crosses borders, in part because ethnic groups and religious confessions transcend international boundaries, but also because millions of people, especially in Africa, have been forced to flee as refugees and immigrants. The United Nations, and its several agencies dealing with issues of health, education and human rights, could play an important role in formulating and co-ordinating action against female genital mutilation. The first steps in this direction have begun, but much more remains to be done.

The beginning of UN involvement

In 1958, the Economic and Social Council (ECOSOC) of the United Nations invited the World Health Organization (WHO) to:

> ***'undertake a study of the persistence of customs which subject girls to ritual operations, and of the measures adopted or planned for putting a stop to such practices'***,

and to communicate the results of that study to the Commission on the Status of Women before the end of 1960. The 12th WHO Assembly in 1959 rejected this request on the grounds that:

> ***'the ritual operations in question are based on social and cultural backgrounds, the study of which is outside the competence of the World Health Organization'***.

WHO were again asked to undertake a study on the subject by the African participants in a UN seminar in Addis Ababa, 'On the Participation of Women in Public Life', and this request was repeated by ECOSOC (Resolution 821 11 (XXXII) adopted 19 July 1961).

There were no further substantive initiatives on the UN level for nearly 20 years.

However, a number of individual initiatives in the following two decades were instrumental in informing the public, in Africa and elsewhere, of the existence and the extent of the practice.

- The Swiss-based Terre des Hommes movement, which aids children in distress, called a widely reported press conference just before the WHO Assembly in Geneva in May 1977. They published two well-documented and illustrated reports on the subject.
- Articles began to appear in African publications, the first of which came out in 1975 in *Famille et Développement*, published in Dakar; an article by Esther Ogunmodede in December 1977 in the magazine *Drum* made a big impact; in August 1978 a long

article entitled 'The Silence Over Female Circumcision in Kenya' appeared in the magazine *Viva*.

- In 1975 the Sudan Family Planning Association (SFPA) magazine, *Happy-Family*, published the papers written on female circumcision in the Sudan contributing to the SFPA Seminar 'The Role of Sudanese Women in Development', held in March 1975 in Khartoum. The SFPA then published a small booklet including all these articles, as well as the recommendations of the seminar. This booklet was widely distributed within the country.
- The research work carried out since 1973 by an intrepid American, Fran Hosken, resulted in her article 'The Epidemiology of Female Genital Mutilations', published in *Tropical Doctor* in July 1978. She has kept up a barrage of questions to international agencies and NGOs to provoke actions and enquiry; the *Women's International Network News* supplies regular information on this and other issues of vital interest to women the world over; in 1979 the second edition of the *Hosken Report – Genital and Sexual Mutilation of Females*, a comprehensive 368-page document, was published.
- The publication in France in 1978 of a book by a young Senegalese woman, Awa Thiam, on the situation of women in Africa, *La Parole aux Négresses*.[7]
- In December 1979, the African Symposium on 'The World of Work and the Protection of the Child', organized by the International Institute for Labour Studies in Yaoundé, Cameroon, strongly recommended the organization of campaigns and of teaching by all educational means, on the dangers of excision. The symposium also urged the International Institute of Social Sciences to constitute a data bank on excision, the evaluation of prevailing attitudes, and the best ways toward elimination.
- The Second Regional Conference (Lusaka, 3-7 December 1979) on 'The Integration of Women in Development' unanimously adopted a resolution condemning infibulation, and called upon African governments to assist national women's organizations in their research for a solution to this problem.

The World Health Organization (WHO)

The first opportunity for discussion provided by the WHO was the seminar on 'Traditional Practices Affecting the Health of Women and Children', organized by WHO Regional Office for the Eastern Mediterranean in Khartoum, in February 1979. Representatives from 10 countries participated: Djibouti, Oman, Egypt, Somalia, South Yemen, Ethiopia, Kenya, Nigeria, Burkina, and of course, Sudan. The task of freeing women and children from a custom with many risks and no advantages for their health, without brutally destroying the cultural fabric, had at last begun on an international level.

The following actions were recommended by the seminar and addressed primarily to the governments concerned:

- Adoption of clear national policies for the abolition of female circumcision.
- Establishment of national commissions to co-ordinate and follow up the activities of the bodies involved, including, where appropriate, the enactment of legislation prohibiting female circumcision.
- Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and undesirability of female circumcision.
- Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice.[8]

These recommendations have been implemented only to a very limited extent. In August 1982, in a statement to the UN Human Rights Sub-Commission, WHO again assured governments of its readiness together with UNICEF to support national efforts against female circumcision.

Yet like other UN agencies, WHO will not support regional or local education programmes organized by NGOs. The request for financial support has to be sanctioned by or come from a government, thus entailing a political decision.

Since 1984, WHO has financed Africa meetings and research (eg. HIV transmission and female genital mutilation) but has not taken a lead on this issue, seeing the responsibility lying with local African initiatives. In 1984, WHO organized a regional workshop under the title 'Women, Health and Development' in Damascus. The workshop was attended by delegates from 15 countries from the region. The subject of female genital mutilation was discussed as one of the harmful practices adversely affecting women's health. It was agreed at this workshop that the responsibility for action lies primarily with the women themselves.

WHO has also been involved in more positive action against the custom by their sponsorship of a film about excision in Burkina Faso, *You will not excise my daughter*. (see section on Burkina Faso)

United Nations Children's Fund (UNICEF)

UNICEF, with children's programmes all over Africa, has tremendous potential to act positively on this issue. It only became active on the subject in March 1980. Given UNICEF's considerable experience in educational work with traditional midwives, and their grassroots work with mothers and children in rural areas, their official professed ignorance of the customs until 1980 is unbelievable. In March 1980 a joint meeting of WHO and UNICEF came up with a joint 'plan of action' endorsing a 'through primary health care' approach, and laying down as an essential principle that all activity should be undertaken through citizens of the countries involved.

The plan recommended:

- Strong advocacy efforts towards WHO/UNICEF staff.

national policy and decision-makers, all health and health-related personnel, and the general public.

- The identification and support of organizations with national structures and credibility in the field.
- Fostering action-oriented research on epidemiology, and socio-cultural studies encompassing behaviour, values and attitudes.
- The dissemination of the results of successful action and research in practising countries.

As far as UNICEF is concerned, responsibility for the implementation of these recommendations:

> *'lies jointly with the individual UNICEF country or area representative and the appropriate government authorities.'*

From the lengthy background papers, it seems that UNICEF have difficulty even persuading their own personnel of the need to eradicate genital mutilation; their inactive approach, apparent in the wording of the above recommendations, is borne out by the fact that no specific funds have been set aside for their implementation.

In April 1985, during the UNICEF Executive Board meeting in New York, the NGO Forum discussed female genital mutilation. The report of the discussion was presented to the UNICEF Board. Both WHO and UNICEF assisted with the setting up of the Inter-African Committee on Traditional Practices (IAC). UNICEF has financed IAC workshops and meetings related to female genital mutilation. Some of UNICEF's country representatives are now beginning to include education on female genital mutilation in their activities at national level.

The United Nations Educational, Scientific and Cultural Organization (UNESCO)

UNESCO maintains total silence on the subject. The question of female genital mutilation has not yet been discussed at any of the many conferences, debates or research studies on cultural patterns in Africa, on social change, education or human rights; nor during the International Year of the Child, in 1979. No UNESCO personnel in the field collect information, stimulate research, or assist with education campaigns. One small change came in November 1980 when it became possible for the Human Rights Division of UNESCO to sponsor research programmes.[1] In December 1988 the Paris based CAMS (Commission Internationale pour L'Abolition des Mutiliations Sexuelles) held a symposium on violence against young girls and women under the auspices of UNESCO in Paris.

The United Nations

The decade from 1975 to 1985 was declared the United Nations Decade for Women. Halfway through this decade in July 1980, a major UN conference was held in Copenhagen to review past progress, concentrating on the sub-themes: health, education and employment. In the 'Review and Evaluation of Progress Achieved in the Implementation of the (1975) World Plan of Action: Health' (document A/CONF.94/9), the subject of female genital mutilation is mentioned once under the sub-heading 'Cultural practices affecting women's health':

> *'Paragraph 45. Female circumcision and infibulation can lead to complications during pregnancy. The Second Regional Conference on the Integration of Women in Development, held at Lusaka from 3 to 7 December 1979, condemned sexual mutilation practices, but was also critical of uninformed international campaigns against these practices, and called upon African Governments and women's organizations to seek solutions to the problem.'*

In the main policy document of the Conference, the 'Programme of Action For The Second Half of the United Nations Decade for Women: Equality, Development and Peace', the subject was not referred to at all by name. Under the section: 'Objectives and priority areas for action taken in connexion with the sub-theme of the World Conference, Employment, Health and Education', paragraph 129 refers to the promotion of:

> *'extensive health education programmes, including special efforts to encourage positive traditional practices, especially breast-feeding, and to combat negative practices detrimental to women's health.'*

No African country took up the issue of female genital mutilation in the official conference. Due to pressure from the Swedish public, the Swedish delegation mentioned the subject, indicating that the Swedish authorities were prepared to support activities undertaken by the countries concerned but would take no action of their own in this respect.

It was the Copenhagen Non-Governmental Organizations Forum, a parallel gathering to the official Conference, which brought the issue to international attention. This more informal forum brought together 8000 women from 120 countries to discuss and plan action on issues of importance to women through workshops and round-table discussions on specific subjects, panel debates on more general themes, through films, slide-shows, lectures and press conferences.

It became evident from the very beginning the extent to which 'female circumcision', as it was largely referred to, was a sensitive subject. The media coverage tended to be 'sensation-prone', focusing upon the process and symptoms of the practice rather than the reasons behind it. Some participants felt that the effect was detrimental, as it increased hostility from decision-makers in the mainly African countries concerned. On the other hand, it was frequently stressed that some years ago it would have been impossible in most countries even to mention the subject in public.

The three pre-planned workshops on the topic expanded to at least seven more. Several groups of participants could be distinguished: those from Eastern Africa; those from West Africa; those from Europe and the US; African immigrants in Europe; Africans studying in Europe, each with different points of view.

The eastern African delegates came from countries where the practices were most severe and campaigns against them most advanced. For example, in the Sudan where campaigns against mutilation were most advanced, the College of Nursing and Midwifery educated against the practice, an educational booklet in Arabic had been developed, and concrete programmes had been started in rural areas with financial assistance from an organization in Sweden. Kenya was also starting a similar project, financed from the same source. Edna Adan Ismail from Somalia, where over 90% of female children are infibulated, described the ways in which the support of her government had been obtained for research and programmes for education towards eradication.

On the other hand, delegates from west African countries were at first shocked and unable to understand the interest shown. They stressed that the abolition of these practices was not a priority for them – sufficient food and clean water having a far greater importance. Expressions of concern were interpreted as outside interference from colonial and neo-colonial states. Representatives from Burkina declared themselves most shocked that the subject was discussed in a session with a French woman in the chair who had no experience of living in an African country. They severely reproached a writer from the USA and did in fact leave a meeting in protest.

The Forum discussions probably made an impact upon some (not all) Westerners who initially had strong views on immediate abolition of this 'barbaric custom'. They became convinced that the only efficient way to support African women working against the practice was by financing and supporting specific projects and educational activities planned and implemented by and with those in the countries concerned, and on their conditions.

As a result of the interaction and discussions at the Forum, many women came to realize that the high degree of emotion that they felt on this subject is to an extent a projection of their own feelings of degradation and sexual abuse, which erupted when faced with such tangible examples of maltreatment of female genital organs.

Other international forums

- In June 1982 the International Council of Nurses adopted a resolution against genital mutilation. In 1983 it adopted a statement concerning human rights directing:

  'the need for nursing actions to safeguard human rights ... where abuse of patients is suspected'.

- At the Fourth International Congress on Child Abuse and Neglect (Paris, 7-10 September 1982) three workshops on the topic were given.

- The International Seminar of the *Commission Internationale pour l'Abolition des Mutilations Sexuelles* (CAMS), held in Dakar, Senegal, 27-29 December 1982, voted to establish a research and education centre in Senegal towards the abolition of these practices.

- A major seminar on 'Traditional Practices affecting the Health of Women and Children' was held in Dakar, Senegal, 6-10 February 1984. The Seminar, which was organized by the UN Working Group on Traditional Practices and was financed by WHO, UNICEF and international NGOs, was well represented by 21 African countries at both governmental and non-governmental levels. At the end of the seminar, African participants voted to form an Inter-Africa Committee to follow up action on the abolition of harmful traditional practices in all countries directly concerned.

- A workshop, 'African Women Speak', in October 1984 organized by Babiker Bedri Scientific Association for Women Studies, Sudan. This brought together African women to discuss strategies for campaigns against sexual mutilation in their own countries and to plan for a workshop on traditional practices for the UN End of Decade Conference on Women, Nairobi, July 1985.

- At the Nairobi conference marking the end of the United Nations Women's Decade in July 1985, separate workshops on female genital mutilation were organized in the NGO forum by the Inter-Africa Committee on Traditional Practices and CAMS.

- In June 1988 in Mogadishu, Somalia, an International Seminar on 'Female Circumcision: Strategies to Bring About Change' was organized jointly by the Somali Women's Democratic Organization and the Italian Association for Women in Development.

- In December 1988 in Paris, CAMS-France organized an international conference on 'Violence and Sexual Mutilation inflicted on Girls and Women'.

- From April to May 1991, the United Nation Human Rights Commission organized its First Seminar on 'Harmful Traditional Practices on Human Rights', in Ouagadougu, Burkina Faso.

The Working Group on Traditional Practices Affecting the Health of Women and Children

A Working Group was formed in Geneva in 1977 by members of NGOs having consultative status with the Economic and Social Council of the United Nations (ECOSOC). These NGOs form part of the Special Committee on Human Rights, and its Sub-Committee on the Condition of Women. The Working Group concerns itself exclusively with excision and its grave consequences for women's health, and on the most effective way of combating these practices. A clear priority is the training of medical and social workers who are in contact with rural populations and disseminating information in the rural areas.

In order that these two initiatives – training and information – have a chance of success, it is indispensable to obtain the agreement and co-operation both of the official bodies and of the women directly concerned.

The Inter-African Committee on Traditional Practices Affecting the Health of Mothers and Children (IAC)

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was formed in 1984 by delegates to the conference on Traditional Practices organized by the UN NGO Working Group on Traditional Practices in Dakar, Senegal. Its present coordinator, Mrs Berhane Ras-Work from Ethiopia, is also the president of the IAC. The IAC with its headquarters in Geneva, Switzerland, lobbies at the UN and has developed national chapters or groups in the following African countries: Benin, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Kenya, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Sudan, Togo.

The IAC believes in a 'softly, softly' approach to the abolition of female circumcision and has gained the support of some of the African ruling elite, such as officials and politicians, as well as of UN agencies, including WHO and UNICEF, and international funding bodies. Its national chapters in Africa conduct information campaigns on the harmful effects of traditional practices. These activities have contributed to raising the awareness of an increasing number of people to the health risks associated with female genital mutilation. The IAC has also organized training for traditional birth attendants and has set up regional meetings between the national chapters.

In May 1984, ECOSOC adopted a resolution under the heading: 'The question of slavery and the slave trade in all their practices and manifestations'. By this resolution the UN Secretary-General was requested to entrust an official UN Working Group, composed of experts, nominated by the Sub-Commission for the Protection of Minorities and the Prevention of Discrimination, with the task of conducting a comprehensive study of the phenomenon of 'Traditional Practices Affecting the Health of Women and Children'. This UN Working Group was established, and first met in Geneva in March 1985. The Working Group discussed many topics on negative traditional practices far greater than that of female genital mutilation, although this remains its main focus.

The United Nations Commission on Human Rights

Action on female genital mutilation

At its session the Working Group submitted a report to the 42nd Commission on Human Rights. The report referred to various traditional practices such as female mutilation, facial scarification, forced feeding of women, early marriage, nutritional taboos, traditional birth practices, and the consequences of preferential treatment for male children.

By its resolution in 1988 on 'Traditional Practices Affecting the Health of Women and Children', the Commission on Human Rights requested the Sub-Commission on Prevention of Discrimination and Protection of Minorities at its 40th session, to consider measures to be taken at the national and international levels to eliminate such practices, and to submit a report to the Commission. Pursuant to this request, the Sub-Commission asked one of its expert members to study, on the basis of information to be gathered from governments, specialized agencies, other inter-governmental and non-governmental organizations concerned, recent developments with regard to Traditional Practices Affecting the Health of Women and Children.

A preliminary report was submitted by the Special Rapporteur to the Sub-Commission in 1989. The report contained replies received from only 16 governments, two UN organizations, one specialized agency and 12 NGOs. In view of the small number of replies received by the Special Rapporteur on this question, the Sub-Commission adopted a resolution in 1989 which recommended that the Commission of Human Rights extend the mandate of the Special Rapporteur to enable her to present a more complex report and to undertake field visits to two countries where harmful traditional practices are prevalent. It also recommended that the Centre for Human Rights should organize regional seminars on the subject in Africa and Asia. In 1990 the Commission on Human Rights endorsed the recommendations.

In 1990 the UN Centre for Human Rights undertook two field missions to the Sudan (see Sudan section) and to Djibouti to assess the progress of work in these two countries. It also organized its first seminar on traditional practices in Ouagadougou, Burkina Faso, in April and May 1991. From detailed discussions which took place, it observed that, despite the seriousness of the problem and the numerous recommendations adopted at international, regional and national levels, the question of Traditional Practices Affecting the Health of Women and Children, especially female genital mutilation, has not received the attention it deserves from most of the states concerned. In the view of the participants, such practices persist because of the lack of political will of many states and the failure to inform and educate the public.

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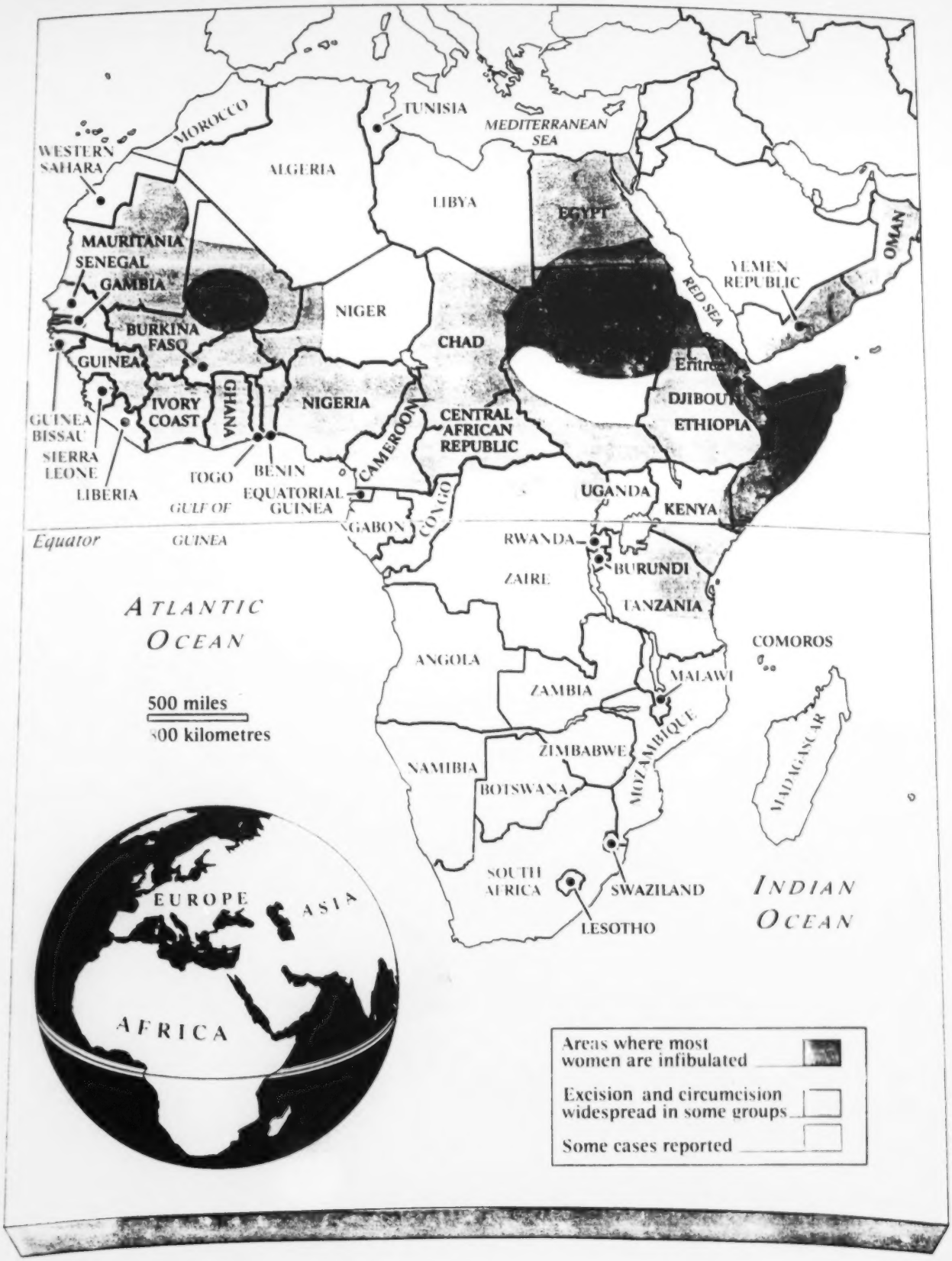
Country	*% of girls operated on*	*female life expectancy against male male=100*	*maternal mortality rate (per 100,000 births*	*under one year mortality (per 1,000 live births*	*under five mortality (per 1,000 live births*	*female literacy rate %*
Somalia	100%	109.1	1,100	127	215	6.0%
Djibouti	100%	N.A.	N.A.	N.A.	N.A.	N.A.
Ethiopia/ Eritrea	90%	106.8	N.A.	130	259	46.7
Mali	90%	109.3	2,000	164	292	11.0%
Sudan (North)	90%	104.0	660	104	181	15.0%
Sierra Leone	90%	110.0	450	149	266	21.0%
Burkina Faso	70%	106.4	810	133	233	6.1%
Gambia	60%	N.A.	N.A.	N.A.	N.A.	15.1%
Ivory Coast	60%	105.8	N.A.	92	N.A.	N.A.
Kenya	60%	106.9	170	68	113	49.0%
Senegal	50%	104.3	600	84	136	19.0%
Egypt	50%	105.1	320	61	125	30.0%
Guinea	50%	102.3	800	140	N.A.	N.A.
Guinea Bissau	50%	107.3	700	146	N.A.	17.3%
Nigeria	50%	106.0	800	101	174	31.0%
Mauritania	25%	108.9	N.A.	122	220	N.A.
Central African Republic	20%	110.6	600	100	223	29.0%
Niger	20%	106.8	700	130	228	9.0%
Chad	20%	106.7	960	127	223	11.0%
Benin	20%	108.9	160	88	185	15.7%
Togo	20%	107.7	920	90	153	28.0%
Ghana	20%	107.5	1,000	86	146	43.0%
Tanzania	10%	107.7	340	102	176	31.4%
Uganda	Under 5%	106.0	300	99	169	45.0%
Zaire	Under 5%	107.8	800	79	138	45.0%
Sub-Saharan Africa	N.A.	106.9	540	108	179	25.2%
Industrial Countries	N.A.	110.1	24	N.A.	N.A.	N.A.

The figures relating to female genital mutilation come from *The Hosken Report*, 1982, copyright Fran P. Hosken. All other information is from UNICEF, *State of the World's Children Report*, 1992, UNDP, *Human Development Report*, 1991 and *Third World Guide*, 1991-2, Instituto de Tercer Mundo, Uruguay.

TILATION IN AFRICA



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PROGRAMMES AND PROPOSALS

Some African and Arab women are speaking out against traditions of female genital mutilation, sometimes at great personal cost. (For example, the Egyptian doctor Nawal El Saadawi, writer on the life of women in the Middle East, lost her job in 1974 as education director in the Egyptian Ministry of Health, to which she had been appointed after 12 years' practice as a doctor in rural areas, after the publication of her book.) They appreciate the resolutions and recommendations resulting from conferences on the subject. But they know that there must be more than resolutions if change is to take place.

The following sections of this report draw on the views of African women in a number of African countries – from the Arab world (Egypt and northern Sudan), from the Horn of Africa (Somalia), from East Africa (Kenya) and from West Africa (Senegal, Burkina Faso and Nigeria).

Over the past decade, programmes have been initiated and developed: some have made progress, others have stagnated and others have been terminated, whether because of obstruction, prejudice, political repression or economic stringency. There is an urgent need for practical programmes, backed by funding. The following sections show how projects have been initiated, assesses the progress made and provides information on new developments.

Let African women speak out

In 1978 a Senegalese woman, Awa Thiam, wrote a book *La Parole aux Négresses*,[4] on the condition of women in Africa. The two major themes of the book are polygamy and genital mutilations, and its strength lies in the authenticity of the evidence, much of it in the form of personal accounts gathered by the author from a number of countries.

She presents, for instance, the case of a mother aged 35, a civil servant with secondary education, who had decided with her husband that their three daughters would not be subjected to the mutilations which she herself had undergone:

> *'They were born in France, while my husband and I were finishing our studies. When we returned to Mali, my mother was the first to ask me if I had had my children excised and infibulated. I replied "no", and stated explicitly that I had no intention of having it done. It was during the holidays. Having found work, I often left my children at my parents and came to fetch them at the weekend.*
>
> *One day, on the way back from work, I went to say hello to them. I was astonished not to see my daughters. Normally they would rush out to greet me. Then I asked my mother where they were. "They're in that room," she replied, indicating the place where they usually slept. I wondered if they were sleeping, or just didn't know that I was there. I went into the room. There they were on the floor, on mats covered with cloths.*
>
> *At the sight of their swollen faces and eyes full of tears, I gasped and cried out: "What is it? What's happened to you, my children?" But even before the little occupants of the room could reply, the voice of my mother reached me: "Don't you go disturbing my grandchildren. They have been excised and infibulated this morning."'*

This young mother, asked her views on putting an end to the practice, replied:

> *'I don't know exactly how, but it doesn't seem to me impossible. At what price I don't know. But nothing can be done towards abolition of these customs if the women concerned do not get together to impose their point of view.'*

Another account is given by a young woman from Mali, who tells how she tried in vain to escape 'opening by the knife' on the eve of her wedding. The attitude of the medical personnel to whom she turned is revealing.

> *'I don't remember anything of my excision or infibulation which were done to me when I was very young. It was only when I was 20, just before my marriage, that I became aware of my condition. I grew up in a closed society, where sex and sexuality were taboo subjects.*
>
> *When I became conscious of my excision and infibulation, I was overcome with a feeling of revulsion. What should I do, I asked myself. For me, there was no question of letting myself be "opened" with a knife on the day of my marriage as is the custom for all women who are both excised and infibulated.*
>
> *Then the idea came to me of getting myself operated on in a hospital. First I went to doctors and then to midwives, but each time I met with a blank refusal. I thought it must be a sort of social consensus. Every single one was against my being operated upon. Every man and woman whom I asked for a hospital operation treated me like a strange animal. One doctor didn't hesitate to say to me: "You want to live a life of debauchery, and for that you are asking my complicity?" I nearly got thrown out of his consulting room.*
>
> *From day to day I lived with my anger and my revolt. I saw to what extent social pressure can be powerful. The day of my marriage approached. The chances of escaping this "opening by the knife" were diminishing. At last, on the eve of my wedding, I had to face my ill fortune and submit to it.'*

A Toucouleur woman from Senegal recounts how she tried, with the aid of her husband and children, to prevent the mutilation of a little girl, Aissata, whom they had taken into their home. But in vain, since Aissata's father took her back by force to her village:

'Several days later, we were informed that Aissata had been excised and infibulated. To our great despair.'

Awa Thiam includes, however, the discordant voice of a young Mali woman with a degree in economics who is pleased to feel no sexual desire at all:

'This demonstrates the function of excision: it permits a woman to be mistress of her body. This is why I don't see it as a mutilation at all.'

What should be done? Awa Thiam feels that there are only two groups of people who want these mutilations to continue: certain Moslem fundamentalists, and some women who hold absolutely to the continuation of these customs in the name of ancestral values. But she thinks that the majority of young girls and children want its abolition.

'The little girl who is excised, even if she wants it because all the little girls of her age are done and because she has been persuaded, doesn't feel any less the terrifying pain. Moreover, she feels deeply the hurt done to her body. She is conscious of being wounded, diminished specifically. Whatever else may be suggested, she experiences a mutilation...'

In the opinion of Awa Thiam, action should be based on precise and objective information, and on women's practical solidarity; in other words, on organized female action.

She emphasizes that clitoridectomy and infibulation are not subjects for discussion for most African men and women. Nor is the condition of women in general:

'In the context of Negro-African mass organizations, whether of the left or of the right, these questions are avoided.'

Thus it is for women to pose the problems which specifically concern them and to work towards their solution.

'There is room to inform women objectively: explain to them the consequences of excision and infibulation. The care of their bodies should be left to adult women.'

It will often be a question of a struggle which the isolated woman may too often lose, as is illustrated by the example of the young woman mentioned above who didn't want to be 'opened by the knife'. However, individual initiative can nevertheless serve at least as a spur and Awa Thiam suggests that already-excised and infibulated women could from now on usefully give an example by campaigning in their own locality.

But their struggle will only be effective if they are unified. Will such a campaign inevitably be anti-male? Awa Thiam's reply is nuanced, and fair: every struggle for the liberation of women will be carried out against certain men, and with others.

Two other points come out strongly from Awa Thiam's perspective: on the one hand, the wish for a vast reciprocal solidarity among oppressed women, whatever their specific struggle; on the other, the realization that the road is a very long one. And it is on this theme that her book concludes:

'Essential, right now are groupings of women quite free of the practices of party politics dominated by the fascism inherent in their structures and phallocratic ideology. At the same time accepting the idea that the liberation of oppressed masses, to be effective, requires a struggle fought with and against women, with and against men. In fact, the solution of the problem of women will be collective and international. Change in their status will be at this price or not at all.

If one just casts an eye over the history of the condition of women – marked by struggles, it has continued to evolve, but at such a pace that it seems that women who struggle for their liberation and at the same time for that of their societies, are undertaking a long drawn-out campaign. In other words, it's a question not of a sprint but of a marathon. So women should prepare with this in mind, in order to succeed.'

25

NORTHEAST AFRICA

In Egypt, at the crossroads of Africa and the Middle East, most women are excised or circumcised, a practice which can be traced back to the pre-Islamic era. The practice, however, is not found elsewhere in the Middle East, with the exception of the countries on the southern coast of the Arabian peninsula.

EGYPT

Marie Bassili Assaad is an Egyptian social scientist who has written on the origins, meaning and traditional values associated with the custom and reviewed current research in Egypt. She has undertaken a pilot study to investigate the present extent of the practice in Egypt and to discover whether, when women were interviewed by other women, they were more willing to answer questions and frankly express their views about their personal experiences.

She concluded that since the practice of female circumcision is so deeply embedded in custom and tradition and shrouded in secrecy, the first step towards eradication is to expose the custom by speaking about it widely, trying to understand the reasons for its perpetuation, and undertaking epidemiological, psychological and sociological research. Such research is a prerequisite for the formulation of training or conscientization programmes for the different target groups: policy makers, opinion leaders, health practitioners (formal and traditional), social workers, feminists, educationalists and other agents of change.

Since the few studies on female genital mutilation at present available in Egypt are not representative, nor do they answer, in a systematic and convincing way, many of the questions posed, further research is needed to equip campaigners with adequately founded arguments against the practice.

Voices from the villages

In a culture where premarital chastity and marriage, two deep-rooted values, are linked with excision of the external genitalia, any physical suffering is preferred to the social ostracism experienced by an uncircumcised girl. Moreover, the rewards offered to the otherwise neglected girl after the operation often make up for any pain or shock. It is important therefore to recognize and respect the validity of women's experiences and feelings.

The following remarks[1] made by a *daya* (traditional birth attendant) in a village in the delta illustrate how strongly embedded is the custom:

> *"Female circumcision is a deeply engrained custom that is passed on from grandmother to mother and daughter. It is done for beauty and cleanliness. The ugly external genitalia, ie. the two leaves (labia minora) must be cut off before they grow too big and dangle like a male organ."*

According to this daya and many of the other women interviewed in an earlier study,[2] all the women they know, whether from their own immediate community, or from other villages, towns, or Cairo itself, are circumcised. They cannot conceive of an uncircumcised woman or girl. This daya described how the people of her village reacted to the rumours that female circumcision was to be banned by the government.

> *"A year ago, when rumours spread around the village that female circumcision will be forbidden, and the government will enforce strict control, families went out at night by lamplight, seeking the help of operators in nearby towns. Many circumcised their daughters before they reached the right age..."*

The following description of this daya's own experience is similar to the stories cited by many of the women interviewed in the study.

> *"I was circumcised at the age of seven, by a woman specialist. My aunt decided to do this favour to my mother. She asked the operator to include me with the other girls from the same alley who were being circumcised that day, and promised to cover all expenses.*
>
> *Once I learned I was going to be circumcised, I was filled with fear and ran as fast as my legs could carry me. Soon the assistant of the operator caught up with me. However, once my aunt saw how pale and frightened I looked, she wanted to put off the operation. The operator categorically refused and retorted: "Do you want to change your mind after all this effort? Whether you have it done now, or put it off to another time, the little girl will experience the same fear. Let us finish with it now."*
>
> *The assistant caught hold of me, stretched my legs apart and the operator sterilized the area with oven ashes and alcohol, and cut off the pieces with a razor. She cut off the tip of the clitoris and the two leaves. Of course I screamed from pain, but soon the pain disappeared and I went off into a deep sleep. I felt fine after two hours. My aunt fed me chicken and offered me special food for one whole week.*
>
> *To demonstrate our privileged new status, all the circumcised girls formed a chain, and walking with our legs apart (sign of circumcision), toured the alley, singing and frolicking."*

Again and again, like the women interviewed in a poor suburb of Cairo, the daya emphasized the importance for people in the village to conform to tradition and customary practices, by making statements such as the following:

'We can't afford being different. We found our mothers circumcised; we learned that our grandmothers and great-grandmothers were circumcised, and we have to carry the tradition to our children and grandchildren. We can't think of anyone who is not circumcised. Once a man divorced his wife as soon as he discovered that, out of negligence, one of her two leaves was not cut off. This man told his wife: "What have I married? A man or a woman?" News of the incident spread and the woman did not know where to hide because of the scandal.'

When asked whether she thought that circumcision affected libido, the daya retorted:

'Of course not. All the women I know, including myself, enjoy our sex life, just as much as our husbands do. We experience orgasm as our men, and derive the same satisfaction. If we were frigid we would have known it.'[48]

Research and action

There is a great gap existing between the vast majority of women living in rural and urban areas, who support the above-expressed views, and the small number of modernized women who ignore the existence of the practice, are shocked when they learn about it, and completely reject it. Therefore Marie Assaad emphasized the need for a two-pronged plan, involving research and action.

Research needed fell into two categories: epidemiological and psychological research which would ascertain the physical and psychological damage caused by the milder ('sunna'), more common, form of circumcision practised in Egypt, complemented by socio-anthropological studies to identify the meaning of the practice in relation to socio-cultural patterns and values concerning women and girls and also male views on the practice.

Research is needed for the planning of programmes and activities aimed at eliminating the practice. Until such knowledge is available, Marie Assaad concluded that the time was not appropriate for open and far-reaching campaigns. Without full control of the situation on the basis of consistent information, such campaigns may run the risk of having a counter-effect on the majority of people. The perpetuators, with their roots in the villages, may either ridicule the unfounded or unsupported views presented, create fresh arguments, or shroud the practice in greater secrecy. Any of these reactions could raise new problems which would impede effective action.

Therefore she recommended that religious leaders should not be a target for action. Both Muslims and Christians in Egypt practise female circumcision, and the practice is perpetuated on the basis of custom and tradition rather than on the basis of religious beliefs. Hence, any undue stress on religious arguments to counteract it may create counter-arguments and runs a high risk of creating religious tension. After active encouragement of some religious leaders to take a stand against the practice, others will inevitably take a stand in support of it, developing a religious opposition to any change. This has been the experience with family planning in Egypt. When much emphasis was laid on religious views, the rejectors have used religion as a camouflage for other objections, and the religious proponents have been accused of adjusting religious beliefs to suit political expediency.

Rather, Marie Assaad urged that initial efforts should be focused on policy-makers, opinion leaders, advocates, educators and health practitioners because of their potential for leadership.

Information should be incorporated in the curricula and training programmes of medical and nursing schools, family planning and social workers. Information manuals based on existing case studies and research findings should be developed and evaluated and adapted. Marie Assaad suggested that one manual should include a number of case studies where women and girls relate their own experience and describe their own reaction to the operation and others should be formulated as a series of questions and answers.

Seminar on 'Bodily Mutilation of Young Females'

This ground-breaking seminar, held in Cairo in October 1979, was presided over by Mrs Aziza Hussein and brought together representatives of the Arab League, UNICEF, WHO, the Sudanese Embassy, the Egyptian Ministry of Social Affairs, the General Organization of Information, Medical Departments of the Cairo Governorate, many NGOs, medical faculties and research institutions.

Participants concluded that female circumcision was a kind of mutilation, that it was harmful, and therefore its confrontation and opposition were imperative. The operation caused psychological trauma which could affect a girl for the rest of her life. It was not recommended by religious belief and if it was prevented would not contradict religious jurisdiction; furthermore, there was no scientific evidence to prove any relationship between circumcision and a girl's femininity and/or chastity.

Projects in Egypt

A three-year project to implement the resolutions passed at the 1979 Seminar was started in October 1982, funded by the Population Crisis Committee and by the Cairo Family Planning Association. A co-ordinator was appointed, and a programme initiated which included the production of education materials and training in their use by doctors, nurses, midwives, social workers and similar groups. A similar programme was developed by the Women's Programme of the Bishopric of Public, Ecumenical and Social Services, in Cairo, backed by the Coptic Orthodox Church in conjunction with the World Council of Churches.

A study by the co-ordinator, based on interviews conducted among 500 women aged between 20 and 30, found that 80% had been circumcised. The main reason given

was that the old customs and traditions were inherited without questioning from previous generations. On the basis of field experience, an information programme was conducted among educated and uneducated groups.

A 12-member national committee was formed to combat female circumcision. Since 1985, it has undertaken public education with a concentration on Mother Child Health Clinics, and family planning centres, with trainers of nurses and social work leaders. It has initiated education for target groups such as secondary school students, young men, female factory workers, etc. To reach out to a wider audience, it has used the media extensively.

A major aim of the project is lobbying to introduce an explicit law which prohibits female genital mutilation, to replace the Ministry of Health's 1959 decree. This decree reformed the practice by modifying it and tried bringing operations into hospitals and surgeries. It has proved woefully ineffective in this aim, and may have had the contrary result of pushing the practice further underground. The National Committee argues that only its legal prohibition will be effective.

SUDAN AND THE HORN OF AFRICA

It is in northern Sudan, Somalia and Djibouti where the greatest concentrations of infibulated women are to be found. In these countries almost all women are infibulated but it is also in these countries that some of the most determined efforts have been made to eliminate the practice.

SUDAN

Sudan has the longest history of efforts to combat female circumcision over a period of 50 years; however, even today more than 80% of Sudanese women continue to be infibulated. Lessons may be learned from the experience of the Sudan, since it is the only country in Africa to have a record of legislating against the practice. Furthermore, as a country with a mixed African and Arab heritage, it has relevance to both the Arabic Middle East and Sub-Saharan Africa.

Midwifery training in the Sudan was instituted by the British in 1921, and by 1948 the midwifery school of the Wolff sisters had trained more than 500 midwives in different areas all over the country. In 1943 a Medical Committee was set up by the then Governor-General to study the problem of female circumcision, resulting in a booklet in Arabic and English, supported by religious leaders, and stating that 'pharaonic circumcision' (infibulation) was cruel and harmful, and should be abolished. This was supported by a press and radio campaign.

None of this had any discernible effect, so in 1946 the government resorted to legislation. Parents hurried to have their children infibulated before the law came into effect, resulting in a higher level of medical complications and deaths. Under the law, midwives performing infibulations were subject to a fine and imprisonment for up to seven years. Such violent disturbances greeted the first arrests that the law was amended and few further prosecutions made. In the words of a Sudanese judge in the 1950s, these events:

> *'... brought to mind the risks involved in the rigid application of the new law without first preparing the people... no social reform could be properly and righteously effected by legislation, particularly when that legislation was imposed by a foreign ruler... the ordinary, modest, bashful Sudanese male, for whose supposed satisfaction women are performing this operation in secret, would not tolerate his womenfolk being dragged into jail or punished for doing what their ancestors had been doing without hindrance for over ten centuries... the only effective way for eradication of that bad and cruel custom is by education of both male and female Sudanese alike.'*

Education for both sexes has since advanced significantly in the Sudan, but surveys and statistics presented to the WHO Seminar in Khartoum in 1979 demonstrated, as far

as infibulation is concerned, that there had been little change. In provincial towns, practically all schoolgirls are infibulated long before they are 10 years old.

Mrs Awatif Osman, Director of the College of Nursing, Ministry of Education, Khartoum, attended the WHO Seminar in 1979, representing the International Confederation of Midwives. She has long years of experience on the subject of female circumcision.

She pointed out that at one time, the mildest (sunna) form of circumcision, which remains legal, was taught in midwifery schools, on the premise that if it was to be done, it should be done in an aseptic manner and with the least amount of mutilation. By 1979 the schools no longer taught any technique, and midwifery trainees were urged to discontinue the practice. In the College of Nursing in Khartoum, the Dean has taught a course in social ethics in which she discusses female circumcision as a mutilation, and the student nurses are made aware of the psychological as well as the medical consequences of the operation.

In spite of these efforts in the clinical field, circumcision persists for socio-cultural reasons, largely because it has a ritualistic importance, and for economic reasons, because it is a source of income for the midwife. Men continue to demand it of their prospective wives, and women continue to have it done since men demand it. Influential people in various places have defied tradition, and while there are clusters of women who have not been circumcised, they are relatively few.

Mrs Osman believes that time and education are essential for the eventual solution of the problem. Knowing why large segments of the population still believe in the practice is essential to developing the strategy to eliminate it. At one stage this research was conducted by teams through the Faculty of Medicine, Khartoum University, through the Ministry of Health, and through Ahfad College for Women, and stress was placed on clinical and social aspects.

Yet the whole issue must be seen in the perspective of the other enormous and urgent health problems. It is counter-productive to focus on this issue in isolation when there are so many problems of maternal and child health to be addressed. Mrs Osman says:

> *'Ultimately, it is a Sudanese problem – a problem of which we are aware and which must be solved by us. In every discussion with Sudanese, the importance of greater literacy is emphasized, especially educational opportunities for women.'*

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El Ham is a young married Sudanese women, with a small daughter. She tells her story.

'I was born here in Khartoum and have lived here all my life. My mother, Amna, is a midwife and like many other midwives earns extra money by doing pharonic circumcisions on little girls. Nearly all women in northern Sudan undergo this operation.

I still remember the day I was circumcised. My story begins when my father was ill in hospital. He opposed circumcision for girls and told my mother that I should remain uncircumcised. But my mother insisted. While he was in hospital she brought another midwife and she circumcised me, telling me that if I told my father they would recircumcise me. The operation was so painful, I couldn't face it a second time.

My father never knew the operation took place. Till the day he died he swore that if my mother did this to me behind his back, he would send her to prison and she would lose her midwife's licence. Of course the operation is forbidden by law and there are very strong restrictions but it doesn't make much difference – the operations continue all the same.

My mother circumcised me because she says it is our custom, our tradition and it gives us women honour. And its her job to do it. Now she says that she must circumcise my daughter for the sake of our honour and tradition. But I don't want this operation to go ahead – in fact I dread it.

I tell my mother that she can't circumcise my daughter. I repeat over and over that it is forbidden by law. But my mother says that it doesn't matter, that it must be done. And she says that my daughter herself will regret not being circumcised. Only two months ago a girl came to her who requested her mother to find her a circumciser, so she could be like all the others. And my cousin who was born in England came to stay with us for a few days and she was also circumcised, without anaesthetics.

I will try to protect my daughter from the knife. My husband agrees with this. There are others who are beginning to think like this now and some doctors and others who are speaking out against the custom. But most people still believe that my mother is right.'

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Adapted from 'Female Circumcision', *Forty Minutes*, BBC2, 3/3/83. Thanks to Louise Panton for allowing MRG to use this material.

Symposium on 'The Changing Status of Sudanese Women'

This symposium was held in February 1979 by the Ahfad University College for Women, in co-operation with interested community leaders, in Khartoum. The recommendations of the symposium on health aspects included the following:

1. The symposium strongly recommended the stopping of female circumcision in all its forms, pharaonic or sunna;

2. A campaign including the use of mass media and curriculum programmes should be carried out to inform the public of the harmful effects of circumcision.

3. Medical experts should convince religious leaders and policymakers of the dangers of circumcision;

4. Traditional midwives who practise circumcision should be trained in other medical or health fields so as to enable them to earn a compensatory source of income.

Among the specific recommendations of the Ahfad Symposium was the forming of a voluntary association. It was later registered under the name of Babiker Badri Scientific Association for Women's Studies, as a tribute to the founder of women's education in the Sudan. This Association undertook the implementation of the symposium recommendations, and, further to group discussions held during the symposium with women leaders from many villages and different provinces of the Sudan, to give priority to:

- Caring for children through women's education;
- Raising future prospects for families through training of mothers in income-generating activities;
- Abolishing female circumcision.

The Sudanese National Committee

The Sudan National Committee on Traditional Practices was set up by the Ministry of Health and Social Welfare in 1984 as the national chapter of the IAC. This committee, however, failed to fulfil its mandate. In 1988, a new Sudanese National Committee (SNC) for the Eradication of Traditional Practices Affecting the Health of Women and Children was formed. It had NGO status and developed a plan of action on training and information campaigns.

UN Centre for Human Rights

In 1989 the UN Sub-Commission on Human Rights recommended that field missions be undertaken to two countries where harmful traditional practices were prevalent. The purpose of the mission was to hold discussions with relevant government officials, national women's associations and members of the international development agencies in order to obtain factual information on the various measures taken or planned to bring a speedy elimination of harmful traditional practices. Sudan was one of the countries chosen for field visits. The mission to the Sudan was undertaken by an official from the UN Centre for Human Rights with Mrs Berhane Ras-Work, the president of IAC, as a consultant. However, deteriorating political conditions within Sudan, plus financial pressures, have made all such programmes aimed at progressive social change much more problematic and difficult.

The team from the UN Centre for Human Rights found that the women's unit and mother-and-child health centres as well as the School of Midwifery were integrating education on female mutilation for their workers and midwives. These, in turn, were encouraged to inform mothers and the public on the health dangers of female genital mutilation. The Ahfad College for Women had also integrated education on female circumcision in its curriculum. Additionally, Ahfad College had a women's association which integrated education on female mutilation in its income-generation project for rural women.

The UN team met with the Attorney-General who explained that he was against criminalizing the practice of female genital mutilation, preferring to include it in the public health ordinance, and follow up with public health education. He stated that Islamic law was already against the practice and, as Sudan had ratified the Convention on the Rights of the Child, this instrument was enough to protect children from traditional practices prejudicial to their health.

Of the UN bodies, the WHO office in the Sudan undertook no activities on female mutilation. UNFPA had initiated and supported TV programmes on female mutilation and UNICEF had included education in its five-year plans.

International NGOs based in Sudan were more active. Radda Barnen and Canadian Save the Children provide financial support for the Sudan National Committee on Traditional Practices, while the Women and Development specialists from the Netherlands Embassy were enthusiastic in support for training programmes for awareness-building among women and the building of infrastructure for women's programmes. They were also tentatively interested in supporting the SNC's work, provided it restructured itself to involve more dynamic and committed members.

SOMALIA

In 1977, when the Somali Women's Democratic Organization (SWDO) was formed, Edna Adan Ismail, an experienced health worker, spoke, with government permission, about infibulation. She was afraid that the great hall full of women 'might throw their shoes at me'. Instead they stood up and applauded. So many individuals then wanted to speak that the assembly broke into smaller meetings; at the end each group in turn called for abolition.

Later, SWDO became the implementing agents for the Commission Concerned with the Abolishment of the Operations, appointed by the Somali government.

In Somalia and in some parts of Africa, the operation is carried out in hospitals under anaesthetics, to eliminate the dangers of the damage and infection posed by the traditional operators. Indeed, the official policy in Somalia has been to encourage the 'less harmful sunna' which consists mainly of a mere pricking of the clitoris to release a drop of blood.[e] This is to win support for the eradication

of the more drastic operation of infibulaton. In Somalia, the operation has now been banned in all government hospitals; the health education campaign centred on proving that there was no rational reason for mutilation – that it was not healthy, not clean, not Islamic, and that it did not even guarantee virginity.

Edna Ismail was emphatic that female genital mutilation must be treated as a health issue. She felt that raising the question of women's sexual freedom would lead to failure. She emphasized that a campaign, from the outside, of alarmist information would provoke 'righteous indignation', and would antagonize people inside Somalia. However, she and other health workers welcomed donations towards research programmes, education campaigns and practical help.

In Khartoum in 1979, at the WHO Seminar, two women representing the SWDO, Raqiya Haji Dualeh Abdalla and Mariam Faraf Warsame, enumerated the measures they saw as necessary to combat mutilations in Somalia. They felt that legislation was essential, but insufficient. They made a number of points:

- Any law must be supported by a day-to-day action campaign, throughout the country, in order to inform women and men of medical facts and encourage them to re-examine their attitudes;
- Religious leaders should speak out publicly against infibulation;
- An intensive education campaign in hospitals;
- Organization of discussion groups among women, workers and young people;
- Establishment of statistics on the basis of irrefutable data gathered by doctors;
- Wide use of the mass media in the aim of informing the population sufficiently that the idea of change can be accepted, and a new relationship between the sexes established.

In 1983, Raqiya Haji Dualeh Abdalla, a sociologist, who later became Deputy Minister of Health, published a book, *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*, which provided unique insights into infibulation and its effects on Somali women. A centre based within the Somalia Academy of Arts and Sciences and funded by the Swedish Agency, SAREC, was set up to conduct studies on the health, psychological and social aspects of the practice.

North/South cooperation

In 1987 the Somali Women Democratic Organization (SWDO), the women's wing of the then ruling party and the Italian Association for Women and Development (AIDOS) commenced a project with two objectives:

- to launch and implement a campaign to eradicate infibulation;
- to strengthen and support SWDO structures in conducting the above campaign.

AIDOS provided technical and methodological support to its Somali counterpart, while SWDO alone was responsible for the content and direction of the campaign. A centre organizing the female anti-mutilation campaign was then set up at SWDO headquarters. In collaboration with ILO-Turin, the project produced five information packages which included audio-visuals for women, young people, religious leaders, medical and paramedical personnel, in the Somali language (which had only been given a script in 1972).

In December 1987, the centre started 'training for trainers' workshops where participants began to use some of the material produced. It then moved on to seminars for women and was successful in organizing a poetry contest on female genital mutilation. In June 1989, an international conference was organized in Mogadishu, on the theme 'Female Circumcision: Strategies To Bring About Change'. The conference ended with firm resolutions which were intended to provide a framework for ongoing action in Somalia. The Somalia Revolutionary Party, the ruling government at the time, gave moral support to the project.

However, the Somali Revolutionary Party, already having lost control over most of the country, was overthrown in early 1991. By the end of 1991, Somalia was in turmoil, torn by clan conflict and anarchy, although a relatively stable, independent administration had been established in the north. The technical base established for the SWDO-AIDOS project was destroyed.

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EAST AFRICA

Excision and circumcision are widely reported in some East African countries, although infibulation seems only to be practised in the remote areas where Kenya borders Somalia. In many East African countries, including southern Tanzania and further south, female genital mutilation does not take place.

KENYA

Mrs Eddah Gachukia, one of five women members of the Kenyan Parliament, has been actively engaged through the National Council of Women of Kenya in efforts to combat mutilation in Kenya. In 1979, she described the situation in Kenya as one in which little or no concrete work or research had been carried out. The National Council of Women of Kenya had appealed to various agencies, including the International Council of Women, UNICEF, the World Health Organization and Fran Hosken, for a grant to enable Kenyan women scholars and gynaecologists from the areas in which female genital mutilation was practised to carry out the reliable studies with which the Council could lobby for government support on the discouragement (if not banning) of the practice. The National Christian Council of Kenya leadership also called for research into the practice in Kenya.

In most parts of Kenya, female circumcision was accepted voluntarily rather than by coercion. The problem therefore had to do more with education (based on full information and knowledge), and specifically with the expansion of girls' education as an alternative means of achieving self-identity, rather than with legislation. It was also important to educate women (mothers and girls themselves) as to the medical complications and their consequences. Mrs Gachukia believed the basis for such education had to emanate from research and data gathered in Kenya. Some work had already been carried about by the University of Nairobi medical school but they needed research funds to continue in a systematic way.

Mrs Gachukia felt that international propaganda was not helpful at the national level especially when this was highly coloured by prejudice, alarmist, and based on erroneous information. International organizations and genuinely interested individuals, she declared, should support local effort and expertise.

From 1982, attempts were made by the Women's Action Group on Excision and Infibulation, formed under the auspices of the Minority Rights Group, to secure funding to support research and to promote education. These efforts were not taken up, and few individuals and groups undertook action in their area. Unfortunately, the National Council of Women of Kenya has been dissolved by the government.

In 1990, however, a Kenyan National Committee on Traditional Practices was established. It plans to carry out a statistical study to find the number of women circumcised and of ethnic groups which continue with the practice, hoping to use this information as a basis for specific projects.

WEST AFRICA

Various forms of female genital multilation are practised in western Africa, although infibulation is found only in some areas of Mali and Senegal. The following accounts come from Nigeria, the most populous state in the African continent, and Burkina Faso (formerly called Upper Volta).

NIGERIA

When Esther Ogunmodede, a Nigerian journalist, began questioning the practice, she sought out other Nigerian women who, like herself, had been circumcised. Her enquiries showed that several hundred thousand excisions took place in Nigeria every year and it was a widely practised tradition. She began to write and speak out against the custom.

In Nigeria, the practice of circumcising females cut across ethnic, religious, cultural and language barriers. Mrs Ogunmodede felt that it would be counter-productive to urge religious leaders to campaign to eradicate it. This was because, firstly, in Nigeria it was not a religious problem – it was simply a cultural custom that had become traditional; and secondly, because religious leaders found it too embarrassing to talk on the subject and considered it outside their province. Yet their support, if it could be enlisted, would be useful, especially in the rural areas where they were often the leaders of society in their communities.

Without doubt, the campaign to eradicate the practice had to be from the medical point of view. It was the only valid reason that could be advanced for wanting to eradicate such a deeply entrenched and widely practised tradition.

Research

Mrs Ogunmodede argued that a campaign had to be predicated on health and medical grounds and that the starting point towards a sustained programme had to be well-ordered research, to compile information and data as to the following factors:

- Which ethnic groups in Nigeria practise female circumcision;
- Their reasons for doing so, in order to allay their fears for discontinuing the practice;
- The numbers of girls and women who have been or are likely to be circumcised;
- The ages at which the circumcision takes place in the different areas;
- The operators or circumcisers and the types of instruments they use;
- How many cases end up in hospitals requiring emergency treatment and other repair jobs;
- The medical as well as the psychological effects of circumcision on the girls.

Research should be initiated by the World Health Organization, UNICEF and other world bodies who could

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provide the material resources and long-term commitment necessary. The programme should co-operate fully with the important Ministries of Health, Education and Information. Special units should be incorporated within the existing framework of the Ministry of Health, drawing on the facilities and resources of the other two ministries to launch a massive educational programme, with the following targets:

1 Maternity Clinics. These clinics in Nigeria usually comprise the antenatal as well as the 'baby' clinics. Here is where the candidates for future circumcision begin their lives, and here is the effective place to begin to educate mothers about the needlessness of the operation as well as its detrimental effects on girls. The talks by nurses and midwives at these clinics to educate the would-be mothers and new mothers about child care are an excellent opportunity to education regarding circumcision. The fact that the two clinics are often in the same building make them ideal places to show films, put up posters and give out leaflets. Husbands, too, could be invited along to see such films.

2 Women's Societies. Contrary to popular opinion held in Western countries, African women rather than men, are the champions of female circumcision. Since mothers are the guardians of their daughters' morals, they have a special interest in preserving their daughters' morality and purity. Therefore, any campaign to abolish the practice should be aimed particularly at the women.

In Nigeria, there are thousands of women's organizations, ranging from church and mosque organizations too cultural and market organizations. Most of these are affiliated to the National Council of Women Societies of Nigeria, which has its headquarters in Lagos. The National Council of Women has co-operated on international bodies in the past and would be best placed to participate in this campaign. In order to reach women in the far reaches of the country, its co-operation is vital. The Council's resources are very limited but, backed with the necessary finance and organization, adequate equipment in the way of films and leaflets in the local vernaculars, the Council could be of immense value to the campaign.

3 Schools and Colleges. A great deal could be achieved in schools and colleges, especially the girls' schools. Information on the effects of female circumcision here could be incorporated in the syllabus for Health Education, Hygiene and Child Care. It is important, however, that teachers are able to obtain the relevant educational aids such as posters, slides or other kits to support their teaching on the subject. The Education Department should ensure that the subject is included in the syllabus and that adequate information reaches the schools.

4 Hospitals, Nursing and Medical Schools. The programme proposed for schools and colleges also applies to nursing and medical schools. Hospitals, including teaching and university hospitals, could play a vital role simply because millions of people pass through their establishments annually. The hospitals should seize every opportunity to acquaint the public of the risks their daughters run by being circumcised. There is a conspicuous lack of educational posters for the benefit of the public in Nigerian hospitals, and the university teaching hospitals are no exceptions.

The question has been raised whether the hospitals should perform the circumcision operations rather than the local operators using crude primitive tools. The idea of having any type of female circumcision performed in hospitals is inappropriate to Nigeria for it would undermine the essence of the entire campaign to eradicate an unnecessary operation, and would put the stamp of approval on a practice that is harmful to women.

5 Legislation. The abolition of circumcision for girls should not be made a matter for legislation as enforcement would prove to be impossible in a country as vast as Nigeria. Moreover, legislation will simply drive the operator underground and have little effect in achieving any measure of eradication.

6 The operation of the campaign. Finally, there should be a well-staffed co-ordinating headquarters for the campaign, to include press and information officers, a well-equipped team of field workers, trained to give talks, set up film shows, and distribute information materials. Moreover, an over-orchestrated campaign would be worse than no campaign at all. It would be greeted with the same scepticism and the suspicion which met the family planning campaign in some areas.

The problem of eradicating female genital operations should be tackled as a health hazard, and no more. The key to the success of the campaign would be a well-ordered and relentless effort for education and enlightenment. Full use should be made of the press whenever necessary to generate public discussion and education in the papers, magazines, radio and television.

Mrs Ogunmodede also tackled the problem of an alternative source of livelihood for the circumcisers. Circumcisers, compared with other professionals, are a very small minority. A rough estimate is one circumciser to about 3000 people in a community. Indeed, a small town may be served by just one circumciser. Even so, the operator does not live by circumcising girls alone; he will always be fully employed circumcising boys, an area about which he enjoys universal support. Besides, the same operator is more often than not a barber, a traditional healer, or a farmer and dabbles in petty trading. The fact that he will now no longer perform female circumcision is unlikely to diminish his income appreciably.

The circumcisers used to perform 'tribal marks', a scarring of the face with designs that made it easy for a person to be recognized by members of his or her own tribe during post-tribal wars in Africa. This practice died out simply because the need for the facial marks had ceased to exist. The great 'razor' families who had made their living performing the facial operations simply turned to other trades. The concern about an alternative source of livelihood for the circumciser in Nigeria is a needless one.

The role of the policy makers

For a campaign to be successful it must gain a significant measure of support from 'policy makers' – the federal and state governments, local authorities, opinion-leaders, the senior officials responsible for the initiation and execution of policies, the media. This support will depend on the method of approach and the level at which participation

and involvement in the campaign is solicited. The international bodies, WHO and UNICEF, have the resources and the authority to motivate the policy-makers.

A limited survey carried out by Drum magazine, following its publication of Mrs Ogunmodede's article in November 1977, showed that policy-makers, no less than the ordinary members of the public, had strong views. Most stated that they would like to see an end to the practice. The publication of the survey further brought in a flood of letters, again the majority being in support of eradication. An outstanding contribution came from the Principal of the School of Nursing in Ife, Mr Olu Babajide, who explained in detail the medical implications of the operation and very strongly condemned female circumcision. There is every indication that people in authority, given the right lead and resources, will support and help to stamp out these dangerous and unnecessary operations.

Research and action

The Medical Women Association of Nigeria (MWAN) has undertaken extensive research into the incidence of female genital mutilation in Nigeria. In 1983 it presented its first report which showed that between 50% and 100% of women in many areas of Nigeria were circumcised, although the practice was more common among some ethnic groups than others. In Ibadan, more than 67% of the women interviewed had been circumcised, and more than 50% planned to circumcise their next female child.

The National Association of Nigerian Midwives (NANM) organized a survey between December 1985 and May 1986 and found that more than 13 states in Nigeria still practised female circumcision. In eight of these states about 90% of the girls were still circumcised. The type of circumcision varied from state to state and according to ethnic groups. Excision occurred in about 45% to 50% of cases studied, while infibulation accounted for 14%.

In 1985, a Nigerian National Committee on Traditional Practices was formed. It has since then engaged in educational seminars and workshops, and radio programmes on female circumcision with diverse groups such as professional women, market women, traditional practitioners, religious leaders, schoolchildren and non-governmental organizations, as well as with representatives from the Ministry of Health.

BURKINA FASO

At the 1979 Khartoum WHO seminar, Alice Tiendregeogon spoke on behalf of the Women's Federation of Upper Volta, later to become the Women's Federation of Burkina. Although infibulation is not practised in Burkina, the attempted suppression of excision in all forms has met with strong resistance from a population consisting of 30% Moslems, 20% Catholics and 50% Animists. The campaign against excision, launched in 1975 and using radio (the only way of reaching remote areas) in all the vernacular languages, provoked such hostile reactions that it had to be discontinued.

From the survey which had been carried out, in answer to the question: 'Why do you practise female circumcision?', all Moslem men replied that it was their religion, whereas non-Moslems and Catholics gave various reasons: custom, hygiene, supposed sterility of the non-excised woman, immorality – 'a non-excised woman goes with a man...' The women, with the exception of a minority of teachers, nurses, doctors and 'modern' midwives, replied that just as their mothers were excised, so they had to follow.

Thus, in Burkina, a decision was made to approach the eradication of excision as a purely medical problem, conferring on a gynaecologist the task of exposing the physical complications of excision, of explaining that excision does not necessarily remove sexual desire in a woman, and that a non-excised woman is in no way automatically immoral.

In 1983, the late President, Captain Thomas Sankara, in response to a visit by a French human rights organization, gave the most radical statement yet made by an African head of state against female genital mutilation. He appealed to Burkina women not to rely on, or to expect, concessions from men but to have the determination to struggle for their liberation.

However, no substantive action took place in Burkina until May 1990 when a National Committee to Combat the Practice of Female Circumcision was created by decree. Burkina women have commenced campaigns in rural areas to alert people to the harmful effects of traditional practices. A draft constitution, on which a referendum was held in June 1991, upholds equality between men and women and provides for the prohibition of female circumcision.

WHO has also joined the campaign against female genital mutilation in the country. In 1991 it made a film which depicted the hold the practice has in the rural areas. It tells the story of a doctor's family from Ouagadougou on their monthly visit to his home village, where he conducts a free clinic. His father, the village chief, wishes to have the eldest daughter, Nafi, circumcised. The father refuses and the matter is discussed at the village council. The chief and most of the village elders defend the tradition but one elder states:

> *'Who are you to attack the doctor... I didn't hear you complaining when doctor operated on your hernia last year... which of us had doctor's knowledge about the goitre. None of us. And which of us has doctor's knowledge about excision. If he says its a dangerous practice, who can refute him? So we should recognize that new knowledge is a good thing, and we should listen to doctor's knowledge about excision'.*

The doctor also talks to the women, in a session chaired by the midwife, answering their questions as to whether unexcised women can give birth safely and the welfare of unexcised children. He also brought a panel of ethical experts into the village, an Islamic imam, a Catholic priest and a Protestant pastor. All spoke against excision, saying that it was a thing of tradition not of religion. The village chief then ordered the villager fetishers to consult the ancestors and ascertain their views. Even the ancestors came out against continuing the custom.

Despite this the elders decided that excision ceremonies should go ahead on three young girls, including Nafi. Luckily Nafi was rescued by police before the operation could take place. The old women who were conducting the operations were arrested. But there was a tragic outcome; one girl, the daughter of the chief fetisher, had already bled to death. The mourning villagers set fire to the 'excision house', and the chief of the village declared that no longer would excisions be allowed in the village.[30]

THE WESTERN WORLD

Until recently, focus on the practice of female genital mutilation has been on the African continent, which has an estimated population of 80 million women and girls who have been excised or infibulated. More recently, it has become apparent that the practice continues, even when people have migrated to societies in which these practices are little known. It is probable that mutilation of girls has been practised clandestinely on girls living and growing up in Europe and other Western countries, ever since African women moved there from areas where female sexual mutilation was practised.

Concern for children growing up in the West at risk of mutilation has been expressed by African women human-rights activists and health and community development workers in close contact with minority communities in Australia, Italy, the Netherlands, Canada, the USA, Belgium, Germany, Finland, Sweden and Norway. In France, children have died as a result of botched operations performed clandestinely by traditional operators. Parents and 'circumcisers' have been prosecuted under the law. In the Somali community in the UK, female genital mutilation is known to be practised.

Parents' desire to 'circumcise' daughters can be so great that, if they are unable to have operations performed by doctors in the health care system, families have been known to pool resources to bring traditional 'circumcisers' from home countries to perform such mutilations clandestinely. Other parents have taken their daughters to Africa or to the Middle East during the long summer vacation for 'circumcision'. The question is how society should deal with immigrant customs which are seen as unacceptable in a new land.

THE UNITED KINGDOM (UK)

In the UK, female genital mutilation is used by families as a powerful weapon to control girls' sexuality and as a means of deterring them from marrying outside their ethnic or religious community. Mutilation affects girls growing up in the West in many ways. For example, tightly infibulated girls have been known to stay longer in the toilet at school as they cannot void easily and may spend from 10 minutes to half an hour urinating. In some cases, urine is forced out drop by drop. Girls may shun vigorous activities such as physical education as they fear that the infibulated scar will split open. They may frequently absent themselves from school, suffering from lower abdominal pain and bladder infections. Other infibulated girls experience severe menstrual pains which may warrant monthly absence from school.

The problem for girls arises as school teachers may not be aware of the condition of their pupils. For fear of mockery from their peers, girls may feel too embarrassed to reveal their condition and therefore live with their discomfort and pain. This has a detrimental effect on their development. Where schools have become aware of the condition of their pupils, a 'culture of silence' often prevails.

Female genital mutilation is a constant source of psychological conflict leading to distortion of the self-image and

This 22-year-old British woman from the Somali community in the UK told her story on the *Forty Minutes* TV documentary in order to aid understanding of the practise of 'female circumcision' and to help other girls from the Somali community to escape it.

'I was born and brought up in Britain, so I've been here all my life. I went to school and college here. I was eight years old when I was circumcised. My two sisters and myself and my mum went to Somalia. I assumed we were going for a holiday to see our family back home. Of course all this took place before the civil war. It wouldn't be safe to go there now.

Anyway, they didn't tell us straight away that we were going to be circumcised but a bit later we were told. The day before our operations were due to take place, another girl was circumcised and she died because of the operation. We were so scared and didn't want to suffer the same fate. But our parents told us it was a religious obligation which they had to fulfil, it was their Islamic duty, so we went.

We fought back. It was terrible, we really thought we were going to die because of the pain, having no anaesthetic. We each had ladies holding us down. You have one lady holding your mouth so you wouldn't scream, two holding your chest and the other two holding your legs. Its the only way they can can operate.

After we were circumcised, we had rope tied across our legs so it was like we had to learn to walk again. We had to try to go to the toilet, if you couldn't pass water in the next 10 days that was a sign that something was wrong and that there was a risk of death. We were lucky I suppose, we gradually recovered and didn't die like the other girl.

But the memory and the pain never really goes. I was really young, you know, what could I do. One of my friends was circumcised at a very late age, in her teen years, so she has a very strong memory of what happened to her and she suffers from nightmares constantly. I don't see myself as getting married. I always feel "Oh, I'm going to have to be reopened and to have that operation again. So I won't even think of getting married."'

Adapted from 'A Cruel Ritual', *Forty Minutes*, BBC2, 21/2/91. Thanks to Louise Panton for allowing MRG to use this material

concept of womanhood of 'circumcised' girls. Teenage girls learn about the functions of their bodies and become suddenly aware of the physiological functions of their normal genitals which have been removed. An articulate young African woman, British-born and educated, is aware of herself and her rights and will not appreciate the fact that her parents have had her circumcised in order to suppress her sexuality. In a helpline organized by FORWARD, many young circumcised women call to seek help on sexuality issues.

Girls will hear discussions of sexuality from their peers and be worried that they are not quite 'normal' or feminine enough. They worry about defibulation and the impact of mutilation in future relationships. They may find out that it is not a religious obligation, as they have been made to believe by their parents, and will feel betrayed.

Attitudes of medical and other professionals

Issues surrounding campaigns for abolition of female genital mutilation in Western countries become complex, as the subject easily evokes passionate sentiments from communities who practise mutilation of girls, and confused debates from the anti-racism lobby as well as racism from the far right. A culture of indifference has thus been built round the mutilation of girls. The attitude of a wide range of professionals involved in health care of mothers, child welfare and child abuse is encapsulated in the comments below, made by a consultant gynaecologist/obstetrician who delivers the babies of infibulated mothers in London:

> ***'Intercourse will be painful, difficult and traumatic and tearing can occur either during intercourse or delivery. To me it looks horrific, it is horrific, but it is their culture and custom. If that's the way the women want it, it's up to them.'***[31]

In a few cases, concerned professionals who feel the need to start preventive work face major difficulties. The experience of Ms X, a liaison health visitor working with patients in a large maternity unit in London, illustrates this:

> ***'When I discovered that a woman had been circumcised, I informed the health visitor (who will take up the after-care) because I was concerned about the welfare of the younger girls in the family. When my manager found out, she was horrified. I was told that this information was confidential and must not be broadcast abroad. When I sought advice from the Health Visitors' Association, I didn't get a clear answer. We need a procedure that is right for the midwives, right for the health visitor, and above all, right for the mothers and children.'***[32]

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Foundation for Women's Health and Development (FORWARD)

FORWARD, founded in 1983, developed out of the Women's Action Group on Female Excision and Infibulation (WAGFEI), the steering group of African and Arabian women set up under the auspices of the Minority Rights Group after the publication of the first edition of this report. The co-ordinator of WAGFEI and, later, Director of FORWARD, Stella Efua Graham (now Dorkenoo) from Ghana, presented a detailed statement on genital mutilation to the UN Working Group on Slavery (Sub-Commission on the Protection of Minorities and the Prevention of Discrimination) in August 1981, and subsequently to the Commission on Human Rights in February 1982. The statement urged the Commission to seek the appropriate channels to see that the governments concerned implemented the recommendations of the WHO 1979 Khartoum Seminar.

FORWARD, as a non-governmental group, promotes good health among African women, with special emphasis on reproductive health. Through the use of the media, training conferences, meetings, lectures and publications, it has successfully brought about cross-cultural international understanding and recognition of female genital mutilation as a major social evil.

FORWARD sees the practice of female mutilation firmly interlocked with gender politics in African communities; the solution lies in a sensitive but firm multi-pronged approach of intervention which would involve public health education, awareness-building on gender issues, and law enforcement on child protection from harmful traditional practices, together with practical strategies to support families who are breaking away, helping them to cope with community pressures to conform.

FORWARD also acts as an enabler for grassroots community development groups. It has assisted with research on female mutilation in Africa, supported efforts in education campaigns and pioneered grassroots educational approaches that place female genital mutilation in its socio-cultural context. Its most successful project has been its work on female genital mutilation with African immigrants in the UK (outlined below). This is recognized and supported by the UK Department of Health.

The First National Conference on Female Genital Mutilation in the UK

In 1989 FORWARD organized the First National Conference on 'Female Genital Mutilation: Unsettled Issues for Health and Social Workers in the UK'. The conference was attended by over 150 health, education and social workers, and representatives from many ethnic minority communities including communities which practise female genital mutilation.

The conference generated a heated debate and concluded that female genital mutilation constituted child physical abuse. Some of the practical strategies proposed are outlined below:

1 That the DHSS (Department of Health and Social Security – now the Department of Health – DH) should alert local authorities and social services to the existence of female genital mutilation and seek to educate their workers about the practice.

2 That DHSS guidelines, which list five categories which merit registration of a child on the 'at risk' register, should be increased so that the risk of female genital mutilation would appear as the sixth category.

3 That social workers, teachers, police, lawyers, judges and, most critically, the educators of these groups, be taught about female genital mutilation.

4 That a consultative body within social services departments incorporating black community members be set up to bridge the community and profession so that there can be community co-operation with respect to this issue.

5 That wardship jurisdiction is perhaps the most appropriate legal strategy where a child is truly at risk. Wardship freezes the situation; the child is not necessarily removed from the home, but all decisions concerning the child are made by the court. [Wardship is no longer appropriate. Protection of children should now be considered under the new Children Act which came into force in October 1991.]

6 Educational programmes concerning the practice that are currently available be expanded and made as widespread as possible.

7 Sub-groups should be set up at local level to sensitize and counsel parents on the ill-effects of female genital mutilation and support parents who might be considering refraining from it.

8 Health workers (particularly school nurses, health visitors, general practitioners, midwives) and school teachers should integrate health promotion and counselling against female genital mutilation and support parents who might be considering refraining from it.

In December 1989, the DH accepted an action plan of FORWARD to expand and to redirect the work started by African women. FORWARD proposed that authorities which had contact with children and could potentially protect them should be involved in the campaign. FORWARD envisaged the long-term protection of children at risk of female genital mutilation being furthered through the following authorities: health, education (schools) and social services.

The UK Children Act 1989

In March 1991, the DH accepted the need to provide new directions for professionals in cases of child protection. This is provided in its revised document, 'Working Together – A guide to arrangements for inter-agency co-operation for the protection of children', which accompanies the new Children Act of 1989.

The Children Act came into force in October 1991. Prevention of female genital mutilation is firmly now on mainstream agenda on child health surveillance and child protection. No longer is female genital mutilation a marginal issue, seen only as a quaint cultural practice of minorities, and its eradication as the sole responsibility of African women.

Increasing numbers of local authorities, who in the past preferred to ignore the problem because of the label 'cultural practice' and because of its inherent race sensitivities, are now beginning to view it as a complex form of child physical abuse and are developing policies and guidelines of good practice for their field workers. Some health authorities are now exploring ways to build partnership with communities for health promotion. Support networks for women have gradually been developed by women themselves. Since 1989, there have been at least seven known cases of suspected mutilation where local authorities have had to intervene to protect children.

DIRECTIONS FOR THE FUTURE

The mutilation of female genitals has been practised in many areas for centuries. The greatest determination, combined with sensitivity and understanding of local conditions, will be needed if it is to be abolished. In every country and region where operations are carried out, the situation is different, as is the political will, whether at local or national levels.

In Western countries the way forward is relatively clear. In Africa the problem is more profound and the economic and political conditions vastly more difficult, while international agencies have hardly begun to explore their potential role.

What all three have in common is that, to date, nearly all programmes have been individual or ad hoc efforts, with little integration into other structures, with minimal evaluation or monitoring, and lacking in long-term goals and strategies. To achieve real change will require more resources, more detailed planning, and more real sustained commitment from governments and international organizations.

In African countries

The abolition of female genital mutilation is the **responsibility of governments** and requires political will. While voluntary organizations can play a valuable role, it is only government who can act to initiate and coordinate action.

Legislation against the practice of female genital mutilation is necessary but can only operate effectively with the development of a parallel system of child protection to educate against the practice and assist in the enforcement of legislation.

In areas where female genital mutilation takes place within the setting of group initiation ceremonies, governments should establish **procedures for timely anticipation** of these ceremonies and for assisting the communities to discontinue the mutilation of young girls as part of these ceremonies.

Government hospitals, clinics and medical centres should not practise any form of female genital mutilation.

There should be supervision and control of **traditional operators** to ensure that operations do not continue.

Education programmes should be **targeted and tailored to the community** and should use appropriate cultural mediums to formulate a strong and unambiguous message against the practice.

Education against the practice should be compulsory for doctors, nurses, paramedics, administrators etc. All health professionals should receive specific **training** on female genital mutilation and its consequences.

There should be intensive **education** against the practice in schools, colleges, teacher training programmes etc.

Good practice should be strengthened, publicized, promoted and integrated in training programmes.

Attention should be paid to the gynaecological and

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psycho-sexual needs of those women who have undergone the operation, including individual and community **counselling**, to allow them to find a new identity outside the context of mutilation, and to help break the generational cycle which sustains the practice.

There should be a programme of education on the **human rights of women and children**, using means such as literacy programmes, gender training, extension workers in schools, radio, TV, women's clubs etc.

Every year there should be a government-backed **'day of action'** against harmful traditional practices and promoting viable alternatives.

In Western countries

Female genital mutilation should be recognized as a form of **child physical abuse** practised on babies and young girls, and should not be dismissed as a harmless cultural practice.

There should be clear and unambiguous **legislation** against the practice of female genital mutilation.

The prevention of female genital mutilation should be incorporated into the framework of **protection of children** from abuse. Guidelines should encompass health, welfare, education, legal provisions etc designated to support and protect children.

A mechanism should be found for **identifying children at risk** of undergoing female genital mutilation and acting quickly and effectively to protect them (as outlined in the UK Children's Act).

Parallel to the above there should be guidelines which focus on **education and persuasion** of families and communities where female genital mutilation has been practised.

Legal measures should be used to combat the practice only as a last resort.

All key professionals (health, education, social workers etc.) working with communities at risk should receive specific **training** on female genital mutilation and its consequences.

Special advisors should be appointed to act as **advisors and mediators** between communities who practise female genital mutilation and professionals.

All **newly arrived communities** who practise female genital mutilation should be informed of child protection mechanisms and legislation against the practice.

All communities who practise female genital mutilation should be given education on the **rights of children** and how risks and abuses of children can be reported to responsible authorities.

There should be resources made available to **rehabilitate women** who have undergone the operation, including gynaecological/psycho-sexual help, together with individual and community counselling.

International agencies

The abolition of female genital mutilation should be firmly **on the agenda** of international agencies and should not be left only to voluntary organizations.

WHO, UNICEF, UNESCO and UNDP should each allocate 0.5% of their total expenditure in the period 1992-2000 on programmes to combat female genital mutilation.

Programmes should be well-funded and properly planned. They should be preceded by pilot projects to determine feasibility and avoid waste of resources. They should have short and long-term goals and be subject to independent evaluation and monitoring. Programmes should concentrate on finding practical solutions at grassroots level and should integrate all aspects of the problem – health, education, welfare, tradition and custom, women and children's rights, development.

Women's health care should be an integral part of any **aid given by donor governments** to health programmes of international agencies. Emphasis should be placed on the currently neglected areas of gynaecological, mental and non-maternity health needs of the woman as a person.

All **development workers** in countries where female genital mutilation is practised, including those working in refugee camps, should be aware of the issue and should be willing to discuss constructive solutions with local communities, health professionals, government officials and others.

All development programmes, including those working with men, should incorporate education on **awareness-building and raising the status of women**. A positive supporting attitude by men can decisively influence the abolition of female genital mutilation.

Aid donors

Genital mutilation of girls should be adopted as a **major human rights and a health issue** of the 1990s. Aid donors have a right and a duty to become involved in its prevention and to place pressure on the relevant governments to undertake effective measures to eradicate it.

In areas where more than 50% of the female population are sexually mutilated, resulting in major physical and psycho-sexual problems for girls and women and placing extra burdens on already inadequately-resourced health care and delivery, aid given towards health programmes should be **tied to proven measures taken by governments** to abolish female genital mutilation.

Donor governments and international agencies should request aid recipients to incorporate in the projects they are funding, measures to **abolish practices sustaining the perpetuation of female genital mutilation**. These practices include: forced marriages of young women; the exacting of large-scale bride price or dowry for the benefit of parents; customary demands for proof of the virginity of young women before or during marriage.

International Public

Sexual mutilation of girls is primarily a violation of a child's fundamental human rights. The international public, whose money supports aid programmes, has a responsibility to request information on those programmes funded by donor governments and international agencies, to eradicate female genital mutilation. This should include independent statistics showing the **reduction of the incidence** of the practice within countries.

●

FOOTNOTES

1 Assitan Diallo, *L'Excision en Milieu Bambara*; unpublished thesis for the Ecole Normale Supérieure, Bamako, Mali. p.20.

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12 From two to 12 weeks, in a survey of some 340 Sudanese women studied by Dr Asma A. El Dareer, Dept of Community Medicine, University of Khartoum, in a communication to a symposium on 'The Changing Status of Sudanese Women', 23 February-1 March 1979.

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14 Dr. Taha Ba'asher, *Psychosocial Aspects of Female Circumcision*, paper presented to the Symposium on the Changing Status of Sudanese Women.

15 These feelings of rejection are clearly articulated by Kenyan girls in 'The Silence over Female Circumcision in Kenya' in *Viva*, August 1978.

16 Q.R. Ghadially, 'All for "Izzat": The Practice of Female Circumcision among Bohra Muslims', *Manushi*, No.66, New Delhi, India, 1991.

17 See map of Childhood Mortality in the World, 1977; Health Sector Policy Paper, World Bank, Washington, 1980. (more recent footnote needed).

18 See Fran Hosken, *op. cit.*, for details and estimates of ethnic groups involved.

19 *F Magazine*, No.4, March 1979 and No.31, October 1980.

20 Marie Assaad, *Female Circumcision in Egypt – Current Research and Social Implications*, American University in Cairo 1979, p.12.

21 The Sudanese law forbidding infibulation was enacted in 1946. In Dr. Shandall's study of 4000 women in Khartoum in 1967, 80% were infibulated. In Dr. El Dareer's report of her current research in the Sudan, 84% of respondents were infibulated.

22 Marie Assaad, *op. cit.*

23 Dr Asma El Dareer, *op. cit.*

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25 Koso-Thomas, *The Circumcision of Women, A Strategy for Elimination*, Zed Books, London, 1987.

26 UN Commission on Human Rights, Report of the Working Group on Traditional Practices Affecting Women and Children, 1986.

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29 Dr Asma A. El Dareer, 'Female Circumcision and Its Consequences for Mother and Child', paper presented to the African Symposium on the World of Work and the Protection of the Child, Yaoundé, 12-15 Dec 1979.

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45 Marie Assaad, *Villagers' Participation in Formal and Informal Health Services in the Village of Babel Wa Kafr Hama, Tala County, Menoufia Governorate.*

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47 *Ibid.*

48 This conforms with the results of the earlier study where 46 of the 49 circumcised respondents reported that they enjoyed sex and were happy with their husbands. *Ibid.*

49 This account was given by Edna Adan Ismail, at a lecture at the Africa Centre, London, in 1980.

50 This account from Robert Lacville, *The Guardian Weekly*, November 1991.

51 *The Independent*, 19/2/91.

52 *Ibid*

Active organizations

Foundation for Women's Health Research and Development (FORWARD)
Africa Centre
38 King Street
London WC2E 8JT, UK
(*Contact for groups in western countries*)

Inter-African Committee on Traditional Practices (IAC)
Affecting the Health of Women and Children
147 Rue de Lausanne
CH -1202
Geneva, Switzerland
(*Contact for groups in Africa*)

UN Working Group on Traditional Practices
UN Human Rights Centre
Palais des Nations
CH -1202
Geneva, Switzerland

Commission Internationale pour l'Abolition des Mutilations Sexuelles (CAMS)
President: Ms Awa Thiam
B.P. 811
Dakar, Senegal

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Tradition! Tradition! A symbolic story on female genital mutilation (useful for schools and for group work), FORWARD, London, UK, 1992.

Another Form of Abuse: Prevention of Female Genital Mutilation (training video for health education and social workers), FORWARD, London, 1992

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Rites, Penny Dedman, 1990 (examines the philosophy and its history; useful for students on gender studies), Concord Video Films, 201 Felixstowe Road, Ipswich, Suffolk, IP3 9BJ, UK.

Seven Drops of Blood (available in Somali, useful for Somali audiences). AIDOS, Via dei Giubbonari, 30 - 00186, Rome, Italy.

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